VOLUME 11 • JULY 1956 • NUMBER

LIBRARY
BOSTON UNIVERSITY

Journal of the AMERICAN MEDICAL WOMEN'S ASSOCIATION

Library of Boston University
School of Medicine
80 E. Concord St.,
Boston, Mass.

Official Publication of

JUL 25 1956

SUPPLEMENT TO DIRECTORY

Rauwiloid®

A FIRST THOUGHT IN HYPERTENSION
EVERY GRADE...
EVERY TYPE

Riker
LOS ANGELES

original alseroxylon — all the desirable alkaloids of India-grown Rauwolfia serpentina, Benth.

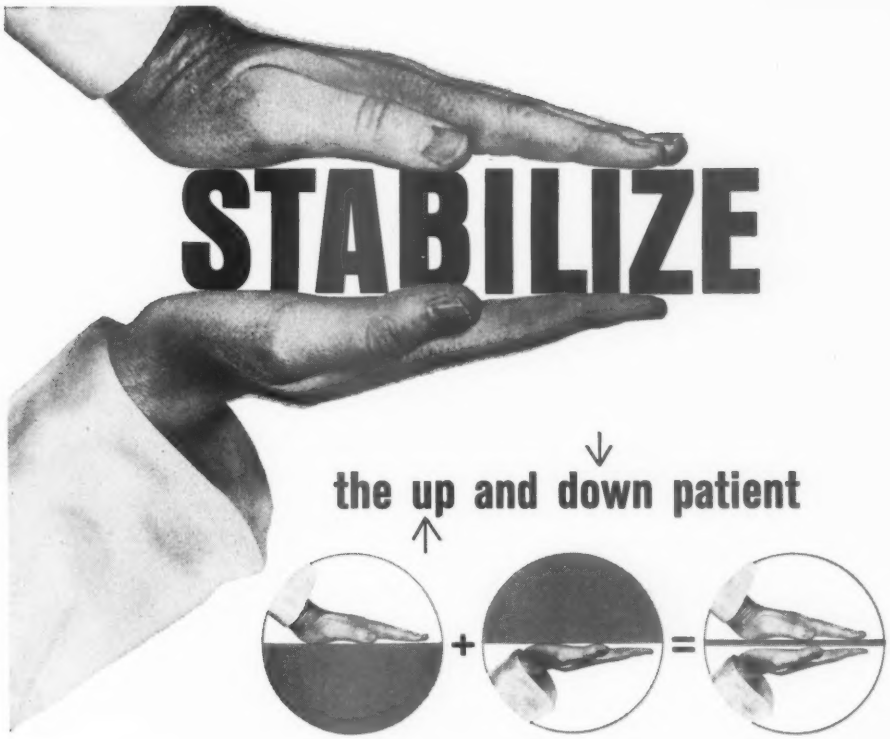
mutually potentiated action — high clinical efficacy because of interpotentiation of contained alkaloids

freed from undesirable alkaloids — yohimbine-like and other undesirable substances in the Rauwolfia root are removed

virtually no serious side actions — when side actions are encountered, they are notably mild

especially suitable for long-term therapy — no alteration in patients' tolerance, no chronic allergic toxicity, no latent undesirable actions

easy to prescribe — simple regimen—merely two 2 mg. tablets at bedtime; for maintenance 1 tablet usually suffices.



To induce emotional equilibrium in those who swing from anxiety to depression, Serpatilin combines the relaxing, tranquilizing action of Serpasil with the mild mood-lifting effect of the new cortical stimulant, Ritalin. In recent months, numerous clinical studies have indicated the value of combining these agents for the treatment of various disorders marked by tension, nervousness, anxiety, apathy, irritability and depression. Arnoff,[1] in a study of 51 patients, found the combination of definite value in a variety of complaints, noting no effect on blood pressure or heart rate. Lazarte and Petersen[2] also found Serpatilin effective in counteracting the side effects of reserpine and chlorpromazine. They reported: "The stimulating effect of Ritalin seemed complementary to the action of reserpine . . . in that it brought forth a better quality of increased psychomotor activity."

1. Arnoff, B.: Personal communication. 2. Lazarte, J. A., and Petersen, M.C.: Personal communication.

Serpatilin Tablets, 0.1 mg./10 mg., each containing 0.1 mg. Serpasil® (reserpine CIBA) and 10 mg. Ritalin® hydrochloride (methyl-phenidylacetate hydrochloride CIBA).

Dosage: 1 tablet b.i.d. or t.i.d., adjusted to the individual.

Serpatilin T.M.

(reserpine and methyl-phenidylacetate hydrochloride CIBA)

CIBA
SUMMIT, N. J.

2/2289M

your allergy patients need a lift

Plimasin®

(tripelennamine hydrochloride and methyl-phenidylacetate hydrochloride CIBA)

What with sneezing, wheezing and scratching, being allergic is fatiguing business. As a result your hypersensitive patients suffer from emotional depression in addition to their allergic symptoms.

Now, with Plimasin, you can give these patients a lift—and obviate sedative side effects. Plimasin is a combination of a proved antihistamine and Ritalin—a new, mild psychomotor stimulant. Plimasin not only relieves the symptoms of allergy but counteracts depression as well.

Dosage: 1 or 2 tablets every 4 to 6 hours if necessary.

Tablets (light blue, coated), each containing 25 mg. Pyribenzamine® hydrochloride (tripelennamine hydrochloride CIBA) and 5 mg. Ritalin® hydrochloride (methyl-phenidylacetate hydrochloride CIBA)

CIBA
SUMMIT, N.J.

2/2267M

Journal of the AMERICAN MEDICAL WOMEN'S ASSOCIATION

VOLUME 11 | JULY 1956 | NUMBER 7

Special Number

WORLD HEALTH ORGANIZATION

SCIENTIFIC ARTICLES

The Control of Poliomyelitis, *A.M.-M. Payne, M.D., M.R.C.P.* 233
International Quarantine, *Yves Biraud, M.D., M.P.H.* 237
World Health Goals in Environmental Sanitation, *Herman G. Baity, Sc.D.* 240
Venereal Disease Control Programme in India, *R. B. Tampi, M.B.B.S.* 243
Some Aspects of International Health Work, *M. G. Candau, M.D., M.P.H.* 246
Leprosy in the Western Pacific Region, *Lawrence O. Roberts, M.D., M.R.C.P., M.P.H.* 251

SPECIAL ARTICLES

Summary of WHO Annual Report for 1955 253
Salk Polio Vaccine
Comments Concerning Administration to Allergic Children, *Jean Crump, M.D.* 255
1956 Emergency Dosage Schedule, *Hart E. Van Riper, M.D.* 255

REGULAR FEATURES

Opportunities for Women in Medicine 258
These Were the First, ELIZABETH BASS COLLECTION 260
Album of Women in Medicine, LILLIE ROSA MINOKA HILL, M.D., *Marcelle Bernard, M.D.* 261
News of Women in Medicine 264
Letters to the Editor 265

AMERICAN MEDICAL WOMEN'S ASSOCIATION

President's Message, *Camille Mermod, M.D.* 257
New Addresses 266

MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION

Council Meeting 257
International Tour: 1956 262

MISCELLANEOUS

Editorial Board ..... Adv. p. 6
Officers of the AMWA ..... Adv. p. 9
Officers of the MWIA ..... Adv. p. 10
Chairmen of Standing Committees ..... Adv. p. 14
General Information ..... Adv. p. 17
Branch Officers ..... Adv. p. 18
Junior Branch Officers ..... Adv. p. 24
Editorial Forecast ..... Adv. p. 27
Index to Advertisers ..... Adv. p. 34
Index to Products Advertised ..... Adv. p. 34

Neither the Editor nor the Publisher of the Journal of the American Medical Women's Association is responsible for any statements made or opinions expressed by any of its contributors.

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is published monthly by the American Medical Women's Association, Inc., at 136 4th Ave., North, Nashville 3, Tenn. Entered as second class matter at the Post Office at Nashville, Tennessee, under the Act of August 24, 1912. Acceptance for mailing at special rates of postage provided for in Section 1102, Act of October 8, 1917, and authorized July 15, 1918.

Copyright 1956 by the American Medical Women's Association, Inc.

Subscription, $5.00 per year; $1.00 single copy.
EDITORIAL AND ADVERTISING OFFICE, Journal of the American Medical Women's Association, 1790 Broadway, New York 19, N. Y. Telephone Judson 6-8683. Advertising Manager, Joseph Bourgholtzer, Box 281, Suffern, N. Y. Telephone Cragmere (N.J.) 8-3870.

Upjohn

Ulcer protection that lasts all night:

Pamine* BROMIDE

Tablets

Each tablet contains:
Methscopolamine bromide ..... 2.5 mg.

Average dosage (ulcer):
One tablet one-half hour before meals, and 1 to 2 tablets at bedtime.

Supplied: Bottles of 100 and 500 tablets

Syrup

Each 5 cc. (approx. 1 tsp.) contains:
Methscopolamine bromide ..... 1.25 mg

Dosage:
1 to 2 teaspoonfuls three or four times daily.

Supplied: Bottles of 4 fluidounces

Sterile Solution

Each cc. contains:
Methscopolamine bromide ..... 1 mg.

Dosage:
0.25 to 1.0 mg. (¼ to 1 cc.), at intervals of 6 to 8 hours, subcutaneously or intramuscularly.

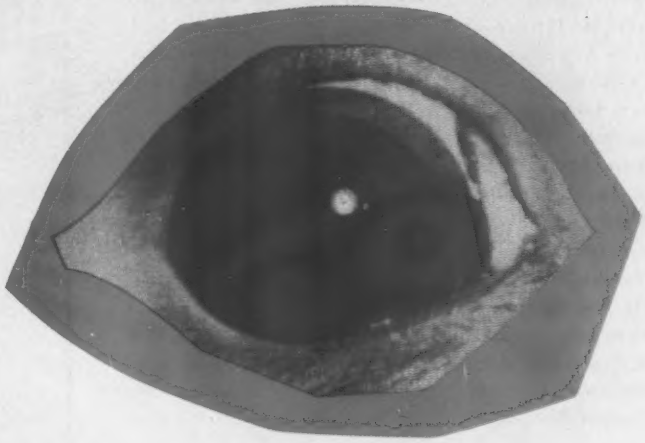
Supplied: Vials of 1 cc.

*TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF METHSCOPOLAMINE

The Upjohn Company, Kalamazoo, Michigan

does not burn or irritate the eyes

PROOF



No evidence of irritation after introduction of Johnson's Baby Shampoo into conjunctival sacs of rabbits three times daily for 15 days.

- nonsensitizing, hypoallergenic
- combats scaling, crusting, cradle cap
- cleanses thoroughly—rinses completely

bettering baby care through specialized research

BABY PRODUCTS DIVISION

Johnson & Johnson

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION
1790 Broadway, New York 19, N.Y.

Editorial Board

JANET K. AITKEN, C.B.E., M.D., F.R.C.P.....*London, England*
INES L. C. DE ALLENDE, M.D.....*Cordoba, Argentina*
MARY M. CRAWFORD, M.D.....*New York, N. Y.*
BEULAH CUSHMAN, M.D.....*Chicago, Ill.*
MARIA PAUMGARTTEN DEANE, M.D.....*Belem, Para, Brazil*
GLADYS H. DICK, M.D.....*Chicago, Ill.*
EDNA M. GUEST, O.B.E., M.D.....*Toronto, Canada*
MARGARET H. JONES, M.D.....*Los Angeles, Calif.*
JOSEPHINE H. KENYON, M.D. .....*New York, N. Y.*
ELIZABETH KITTREDGE, M.D.....*Washington, D. C.*
IRENE A. KOZNEKE, M.D.....*Halstead, Kansas*
ESTHER P. LOVEJOY, M.D.....*New York, N. Y.*
CATHARINE MACFARLANE, M.D.....*Philadelphia, Pa.*
MINNIE LEE MAFFETT, M.D.....*Dallas, Texas*
DAME A. LOUISE MCILROY, O.B.E., M.D.....*London, England*
HARRIETT C. MCINTOSH, M.D.....*New York, N. Y.*
LOUISE PEARCE, M.D.....*Princeton, N. J.*
GILDA PERAZA, M.D.....*Havana, Cuba*
ELLEN C. POTTER, M.D.....*Trenton, N. J.*
BARBARA B. STIMSON, M.D.....*New York, N. Y.*
EDNA H. TOMPKINS, M.D.....*Boston, Mass.*
RUTH WELLS, M.D.....*Pasadena, Calif.*
PRISCILLA WHITE, M.D.....*Boston, Mass.*

Specialists

Anesthesiology.....VIRGINIA APGAR, M.D., *New York, N. Y.*
Cardiology.....TERESA MCGOVERN, M.D., *New York, N. Y.*
Endocrinology.....RITA FINKLER, M.D., *Newark, N. J.*
Gastroenterology.....MARIE ORTMAYER, M.D., *Chicago, Ill.*
Gynecology.....ELOISE PARSONS, M.D., *Chicago, Ill.*
Neurology.....KATE CONSTABLE, M.D., *New York, N. Y.*
Nutrition.....GRACE GOLDSMITH, M.D., *New Orleans, La.*
Obstetrics.....ANNE S. MASTER, M.D., *Cleveland, Ohio*
Orthopedic Surgery.....RUTH JACKSON, M.D., *Dallas, Texas*
Pathology.....EDITH L. POTTER, M.D., *Chicago, Ill.*
Pediatrics.....MARY B. OLNEY, M.D., *San Francisco, Calif.*
Physical Medicine and Rehabilitation.....NILA K. COVALT, M.D., *Lake Park, Fla.*
Plastic Surgery.....ALMA DEA MORANI, M.D., *Philadelphia, Pa.*
Psychiatry.....ANNA COYNE TODD, M.D., *Washington, D. C.*
Public Health.....HELEN M. WALLACE, M.D., *New York, N. Y.*
Radiology.....ELIZABETH SCHULZE HEALD, M.D., *Berkeley, Calif.*
Surgery.....ANNELLA BROWN, M.D., *Boston, Mass.*
Urology.....OCCO E. GOODWIN, M.D., *San Francisco, Calif.*

EDITOR
M. EUGENIA GEIB, M.D.

ASSISTANT EDITORS
MARCELLE BERNARD, M.D.
MARGARET S. TENBRINCK, M.D.

MANAGING EDITOR
ELIZABETH C. SMITH

BUSINESS MANAGER
HELEN M. GROFIK

DEPARTMENTAL EDITORS

Recent Advances in Medicine
FRANCES L. BOGATKO, M.D.
New York, N. Y.

Modern Concepts of Physiology
ESTHER M. GREISHEIMER, M.D.
Philadelphia, Pa.

Seminars on Therapy
FRIEDA BAUMANN, M.D.
Philadelphia, Pa.

Book Reviews
MARGARET HAY EDWARDS, M.D.
Philadelphia, Pa.

HELEN STEVENS HASKELL, M.D.
New York, N.Y.

Reports of Proceedings
MARGARET S. TENBRINCK, M.D.
New York, N. Y.

Medical School Student News
EVA F. DODGE, M.D.
Little Rock, Ark.

Chairman of Publications Committee, ELIZABETH S. WAUGH, M.D., Philadelphia, Pennsylvania

help assure optimal nutrition
during gestation...throughout lactation

NATABEC® KAPSEALS®

vitamin-mineral combination

You can help assure optimal nutrition in your patients during pregnancy and lactation by supplementing their diet with NATABEC Kapseals. Designed to improve intake of important vitamins and minerals at these times of increased nutritional need, NATABEC Kapseals, taken regularly, help avoid complications and aid in safeguarding the health of both mother and child.

dosage: As a dietary supplement during pregnancy and lactation, one or more Kapseals daily. NATABEC Kapseals are available in bottles of 100 and 1,000.

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

80062

Flexible vitamin B_{12} therapy for patients of all ages

Redisol®

CRYSTALLINE VITAMIN B_{12}

MAJOR ADVANTAGES: Increases appetite, helps patients gain weight. Stimulates hemopoiesis. Available as Elixir, Tablets and Injectables for maximum flexibility of dosage. Elixir and Tablets readily blend with milk, juices, infant formulas.

Supplied as REDISOL Soluble *Tablets:* 25, 50, 100 *mcg.*; cherry-flavored *Elixir:* 5 *mcg.* per 5 cc.; *Injectable:* 30, 100, 1000 *mcg.* per cc.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF
MERCK & CO. INC.

AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

1790 Broadway New York 19, N.Y.

APPLICATION FOR JUNIOR MEMBERSHIP

Name .....
(Please Print or Type)

Date .....

Address (Present) .....

Address (Permanent) .....

(Please check address to which the JOURNAL and AMWA correspondence are to be mailed.)

Medical School ..... Year of graduation .....

Place of expected internship .....

Date and place of birth .....

Junior membership does not require payment of dues.

Signature .....

Sh-hh

Placidyl

(ETHCHLORVYNOL, ABBOTT)

nudges your patient to sleep

PLACIDYL enables the physician to *induce* sleep instead of *imposing* it. Non-barbiturate. No initial excitation or respiratory depression.

A halogenated carbinol, sold under no other trade name. Abbott

607019

itching scalp?

scaling scalp?

burning scalp?

Selsun®

relieves seborrheic dermatitis of the scalp and dandruff -quickly, easily, economically.

Just one or two Selsun applications relieve itching, burning scalps. Scaling is completely controlled in 81-87% of seborrheic dermatitis, 92-95% of dandruff cases. And relief lasts—up to four weeks—with each pleasant application. Selsun Suspension is sold only on prescription, in 4-fluidounce bottles with directions.

Abbott

American Medical Women's Association, Inc.

BOARD OF DIRECTORS
1956-1957

OFFICERS

President: CAMILLE MERMOD, M.D., 15 Washington Street, Newark, New Jersey.
President-Elect: ELIZABETH S. KAHLER, M.D., 3828 Fulton Street, N.W., Washington, D.C.
Retiring President: ESTHER C. MARTING, M.D., 2314 Auburn Avenue, Cincinnati, Ohio.
First Vice-President: EDITH PETRIE BROWN, M.D., 441 Turney Road, Bedford, Ohio.
Second Vice-President: GERTRUDE FLINT JONES, M.D., 490 Post Street, San Francisco, California.
Recording Secretary: ANAH WINEBERG, M.D., 3120 Webster Street, Oakland, California.
Corresponding Secretary: FRANCES ARTHUR, M.D., 138 Westfield Avenue, Elizabeth, New Jersey.
Treasurer: ELIZABETH R. FISCHER, M.D., 10401 South Bell Avenue, Chicago 43, Illinois.
Assistant Treasurer: MARY MARGARET FRAZER, M.D., 76 W. Adams Street, Detroit, Michigan.

PAST PRESIDENTS

ELIZABETH S. WAUGH, M.D., 348 Green Lane, Philadelphia 28, Pennsylvania.
AMEY CHAPPELL, M.D., 795 Peachtree St., N.E., Atlanta, Georgia.
EVANGELINE STENHOUSE, M.D., 55 E. Washington St., Chicago 2, Illinois.
JUDITH AHLEM, M.D., 954 South L St., Livermore, California.

REGIONAL DIRECTORS

New England (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut):
CLAIRE F. RYDER, M.D., Rice Island, Cohasset, Massachusetts. (1955-1958)

North Atlantic (New York, Pennsylvania, New Jersey, Delaware):
ALMA DEA MORANI, M.D., 3665 Midvale Avenue, Philadelphia, Pennsylvania. (1955-1957)

Middle Atlantic (Maryland, District of Columbia, Virginia, West Virginia, Foreign):
ELEANOR SCOTT, M.D., 1014 St. Paul St., Baltimore, Maryland. (1954-1957)

South Atlantic (North Carolina, South Carolina, Georgia, Florida, Puerto Rico):
R. CHARMAN CARROLL, M.D., 406 Montford Ave., Asheville, North Carolina (1954-1957)

Northeast Central (Ohio, Indiana, Illinois, Michigan, Wisconsin):
MARGARET STANTON, M.D., 5625 West Division, Chicago, Illinois. (1955-1958)

Southeast Central (Kentucky, Tennessee, Alabama, Mississippi, Louisiana):
MARGARET L. KERR, M.D., Charity Hospital, New Orleans, Louisiana. (1954-1957)

Northwest Central (Minnesota, Iowa, North Dakota, South Dakota, Nebraska):
GRACE SAWYER, M.D., Woodward, Iowa. (1955-1957)

Southwest Central (Missouri, Arkansas, Kansas, Oklahoma, Texas):
ANITA JOHNSON MCNEELY, M.D., 1719 Pacific Avenue, Dallas, Texas. (1955-1957)

Northwest (Montana, Wyoming, Idaho, Washington, Oregon, Alaska):
IRENE GRIEVE, M.D., 525 Fernwell Bldg., Spokane, Washington. (1956-1959)

Southwest (Colorado, New Mexico, Utah, Arizona, California. Nevada, Hawaii):
PEARL KONTTAS, M.D., 114 Sotoyome Avenue, Post Office Box 1374, Santa Rosa, California. (1956-1959)

* * * *

Director of Junior Membership:
ESTHER C. MARTING, M.D., 2314 Auburn Avenue, Cincinnati, Ohio

* * * *

Chairmen of Standing Committees (see pages 19, 20)

* * * *

Editor of the Journal of the American Medical Women's Association:
M. EUGENIA GEIB, M.D., 1790 Broadway, New York 19, New York.

HEADQUARTERS: 1790 Broadway, New York 19, N.Y., Circle 5-8000, ext. 8
Executive Secretary: LILLIAN T. MAJALLY

Medical Women's International Association

President: Dr. M. Yolanda Tosoni Dalai, 1, via Giustiniano, Milan, Italy.

Past President: Dr. Ada Chree Reid, 118 Riverside Drive, New York 24, U.S.A.

Hon. Treasurer: Dr. H. de Roever-Bonnet, J. van Eyckstraat 8, Amsterdam, Holland.

Hon. Secretary: Dr. Janet K. Aitken, Acacia House, 30a Acacia Road, Regent's Park, London, England.

Vice-Presidents: Prof. Marie L. Chevrel, 14, rue des Fossees, Rennes, I. et V., France.

Dr. Inger Haldorsen, Rikard Nordraksgtn 4, Bergen, Norway.

Dr. Anna Jacob-Peller, 23 Mazastr, Tel-Aviv, Israel.

Dr. Fe del Mundo, 34 Kitanlad, Quezon City, Manila, Philippines.

Dr. Anna Walthard-Schaetti, Eierbrechstr. 71, Zurich 7, Switzerland.

Dr. Marion Hilliard, 716, Medical Arts Bldg., Toronto, Canada.

National Corresponding Secretaries

Australia: Dr. Dorothea Heitman, 218, Henley Beach Road, Torrensville, Adelaide, South Australia.

Austria: Dr. Lore Antoine, Wickenburgerstr. 26, Vienna 8.

Canada: Dr. Ruth Harvey, Box 240, Olds, Alberta.

Denmark: Dr. Agnete Heise, Ostergade 18, Copenhagen.

Finland: Dr. Ruth Wegelius, Ostra Brunnsparken 80, Helsinki.

Formosa: Dr. Chang-Sun Fan, 12, Passage 7, Lane 8, Kwangchow St., Taipei.

France: Dr. J. Sorrel-Déjèrine, 123, rue de Lille, Paris 7e.

Germany: Dr. Grete Albrecht, Heilwigstr. 12, Hamburg 20.

Great Britain: Dr. Joy Patrick, 22 Ovington Street, London, S.W.3.

Holland: Dr. Cornelia Middelhoven, Rubensstraat 62, Amsterdam.

Hong Kong: Dr. Marie H. Feng, 221d, Nathan Road, Kowloon.

India: Dr. O. Saldanha, Cama and Albless Hospital, Bombay 1.

Iran: Dr. Habibe Sabri, Hospital, Av. Farvardin, Street Haghi Ghat, Teheran.

Israel: Dr. Jona Rubinstein, 20 Mapustr., Tel-Aviv.

Italy: Prof. M.-T. Casassa, via Principe Amedeo 52, Turin.

New Zealand: Dr. Grace Stevenson, Flat 4, 34, Heriot Row, Dunedin.

Norway: Dr. Estrid Guldberg, Stortingsgtn 22, Oslo.

Philippines: Dr. Iluminada Santiago Lotho, Director, St. Anne's Hospital, 32, Del Pan, Sta Ana, Manila.

Spain: Dr. Elisa Soriano, Mayor 71, Madrid.

South Africa: Dr. Mary Tomlinson, 64, Galway Road, Parkview, Johannesburg.

Sweden: Dr. Ulla Gordh, J. O. Wallinsväg 6, Stockholm 60.

Switzerland: Dr. Ilse Schnabel, Bergstr. 139, Zurich 7.

Thailand: Dr. Pierra Vejjabul, 187, Sathorn Road, Bangkok.

United States: Dr. M. Eugenia Geib, 1277 Clinton Place, Elizabeth 3, N.J.

TAMPAX

a clinically accepted method of menstrual hygiene

"Free from harm or irritation to the vaginal and cervical mucosa."

Karnaky, K. J.: Western Journal of Surgery, Obstetrics and Gynecology, Vol. 51, pp. 150-152.

"No evidence that the use of the tampon caused obstruction to menstrual flow."

Thornton, M. J.: American Journal of Obstetrics and Gynecology, Vol. 46, pp. 259-265.

"Does not impair standard anatomic virginity."

Dickinson, R. L.: The Journal of the American Medical Association, Vol. 128, pp. 490-494.

"Easy and comfortable to use and eliminated odor."

Sackren, H. S.: Clinical Medicine, Vol. 46, pp. 327-329.

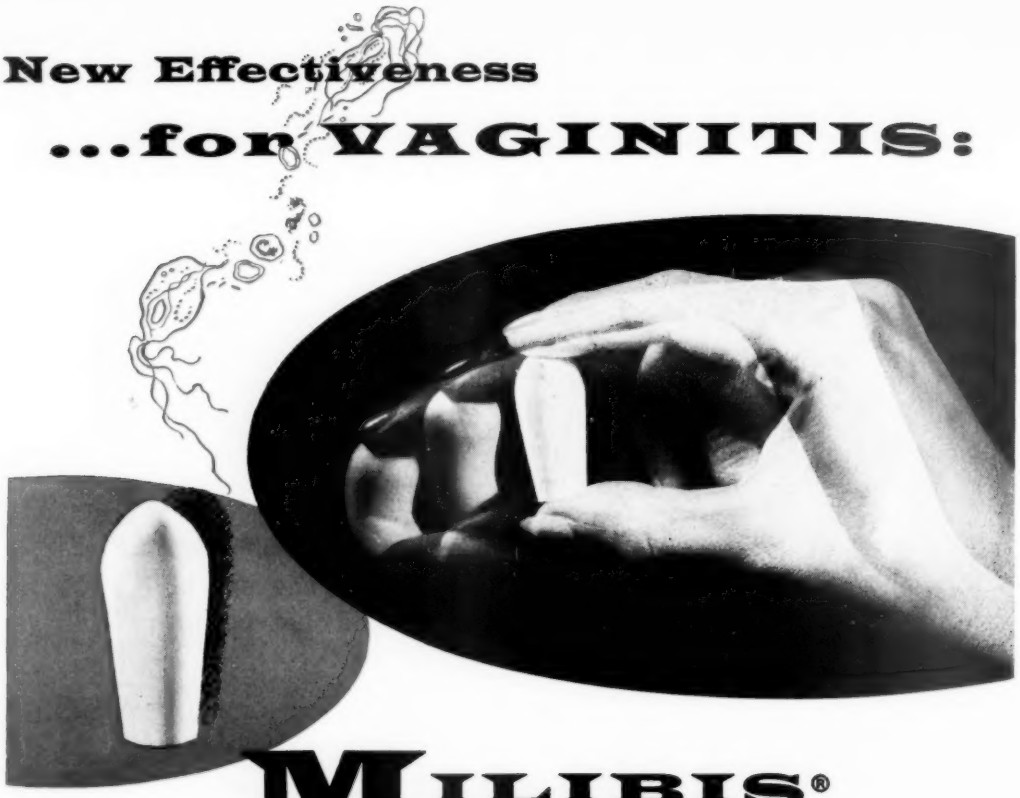
Three absorbencies: Junior, Regular, or Super Tampax meet varying requirements.

TAMPAX

Professional samples and reprints of these papers furnished on request.

Tampax Incorporated, Palmer, Massachusetts

New Effectiveness ...for VAGINITIS:



MILIBIS®

Vaginal Suppositories

—soft and pliant as a tampon—white, odorless, non-staining—the suppositories bring new ease and new effectiveness to treatment of vaginitis.

SUPPLIED: BOXES OF 10

ELIMINATE SMEAR EXAMINATIONS*

Milibis vaginal suppositories are effective in trichomonad, Candida (monilia) as well as mixed and bacterial infections—thus laboratory identification of the offending organism is unnecessary.

THERAPEUTIC REGIMEN IS SHORT AND SIMPLE

A total of only 10 suppositories (one inserted every other night) has given a remarkable rate of cure of over 90 per cent in two large series of cases. Milibis vaginal suppositories are easily inserted high into the vagina and form a tenacious film which coats the cervix and rugae, killing pathogens on contact. Non-staining, well tolerated.

*Except when gonorrheal infection is suspected.

Winthrop LABORATORIES • New York 18, N.Y.

Milibis (brand of glycobiarsol), trademark reg. U.S. Pat. Off.

BETTER

results are obtained with STERANE[1]—3 to 5 times more active than hydrocortisone or cortisone.

BREATHING

capacity is greatly enhanced. "Relief of symptoms is more complete and maintained for longer periods with relatively small doses."[2]

BALANCE

of minerals and fluids usually remains undisturbed. This proves "especially advantageous in those patients with cardiac failure requiring therapy . . ."[3]

in bronchial asthma

Sterane®

brand of prednisolone

Supplied: White, 5 mg. oral tablets, bottles of 20 and 100. Pink, 1 mg. oral tablets, bottles of 100. Both deep-scored.

1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

American Medical Women's Association, Inc.

CHAIRMEN OF STANDING COMMITTEES, 1956-1957

Auditing

Dorothy M. Rogers, M.D.
50 Cooper St., Woodbury, N. J.

Credentials

Rosa Lee Nemir, M.D.
303 E. 20th St., University Hospital
New York 3, N. Y.

Constitution and By-Laws

Eva Brodkin, M.D.
365 Osborn Terrace, Newark 8, N. J.

Elections

Mathilda Vaschak, M.D.
104 Myrtle Ave., North Plainfield, N. J.

Finance

Antoinette Lemarquis, M.D.
704 Medical-Dental Bldg., San Diego, Calif.

History of Medicine

Margaret Kleinert, M.D.
23 Bay State Road, Boston 15, Mass.

International

Ada Chree Reid, M.D.
118 Riverside Drive, New York 24, N. Y.

Legislative

Alma Jane Speer, M.D.
3232 Garfield St., N.W., Washington, D. C.

Library

Rose Menendian, M.D.
6900 N. Western Ave., Chicago, Ill.

Medical Education

Elizabeth Veach, M.D.
Overlook Sanatarium, New Wilmington, Pa.

Medical Service—American Women's Hospitals

Esther P. Lovejoy, M.D.
50 W. 50th St., New York 20, N. Y.

Nominating

Esther C. Marting, M.D.
2314 Auburn Ave., Cincinnati, Ohio

Opportunities

Eloise Parsons-Baker, M.D.
30 No. Michigan Ave., Chicago 2, Ill.

Organization and Membership

Gertrude Flint Jones, M.D.
490 Post St., San Francisco 2, Calif.

Publications

Elizabeth S. Waugh, M.D.
348 Green Lane, Philadelphia 28, Pa.

Public Health

Eleanor Byers Petrie, M.D.
304 Wilton Drive, Decatur, Ga.

Public Relations and Publicity

Mary Tyler, M.D.
1435 North Ave., Waukegan, Ill.

Scholarships

Ann Gray Taylor, M.D.
6364 Germantown Ave., Philadelphia 44, Pa.

Woman's Medical College of Pennsylvania

Catharine Macfarlane, M.D.
701 Medical Arts Bldg., Philadelphia, Pa.

Reference Committee A

Josephine Renshaw, M.D.
1150 Connecticut Ave., Washington 6, D. C.

STATE DIRECTORS

Connecticut: Sophie C. Trent, M.D., 236 West Main Street, Meriden, Conn.
Eastern Massachusetts: Claire F. Ryder, M.D., Rice Island, Cohasset, Mass.
Indiana: Clementine Frankowski, M.D., 1907 New York Avenue, Whiting.
Ohio: (Co-Chairmen): Marjorie Grad, M.D., 1506 Chase Avenue, Cincinnati.
Jeanne E. Nitchals, M.D., 2205 Beechmont Avenue, Cincinnati.
Illinois: Rose Menendian, M.D., 2400 West Morse Avenue, Chicago.
Iowa: Evlyn M. Anderson, M.D., 816 Equitable Bldg., Des Moines.
New Hampshire and Vermont: Augusta Foster Law, M.D., 16 South Street, Milford, N.H.
Pennsylvania: Rebecca M. Rhoads, M.D., 416 Chichester Lane, Wynnewood, Pa.
Western Massachusetts: Mary C. Shannon, M.D., 28 Pleasant Street, Worcester, Mass.
Wisconsin: Elsine Moore Thomas, M.D., 200 East Wells Street, Milwaukee.

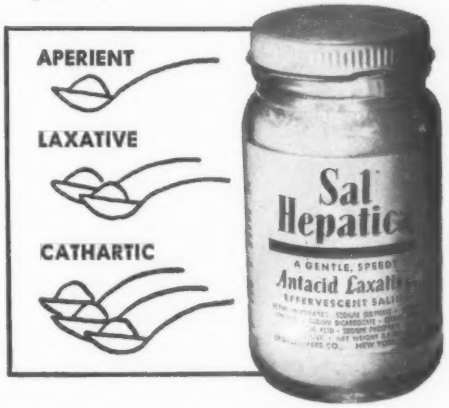
THREE GENERATIONS OF PATIENTS HAVE TAKEN ANTACID, EFFERVESCENT

Sal Hepatica®

Since 1897, sparkling SAL HEPATICA has given prompt, gentle relief of constipation. Because it is both antacid and effervescent, SAL HEPATICA passes rapidly through the stomach. In the intestine its osmotic action provides liquid bulk to stimulate peristalsis, hasten evacuation.

Taken half an hour before the evening meal, pleasant-tasting SAL HEPATICA usually acts before bedtime. Taken before breakfast results may be expected in an hour.

SAL HEPATICA is mild, relieves without griping. Being antacid, it alleviates the gastric hyperacidity which frequently accompanies constipation.



BRISTOL-MYERS CO., 19 West 50 Street, New York 20, N. Y.

In deference to her daintiness . . .

- Massengill Powder is buffered to *maintain** an acid condition in the vaginal mucosa.
- Massengill Powder has a low surface tension which enables it to penetrate into and cleanse the folds of the vaginal mucosa.
- Massengill Powder has a "clean" antiseptic fragrance. It enjoys unusual patient acceptance.
- Massengill Powder solutions are easy to prepare. They are nonstaining, mildly astringent.

massengill powder®

when recommending a vaginal douche

indications:

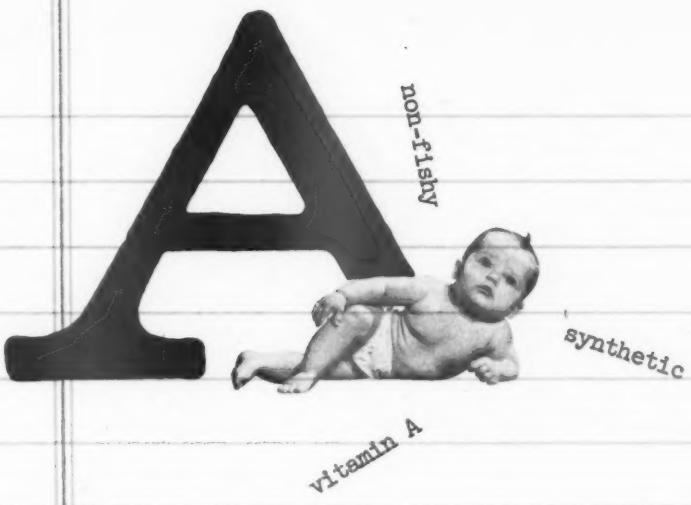
Massengill Powder solutions are a valuable adjunct in the management of monilia, trichomonas, staphylococcus, and streptococcus infections of the vaginal tract. Routine douching with Massengill Powder solutions minimizes subjective discomfort and maintains a state of cleanliness and normal acidity without interfering with specific treatment.

*In a recent clinical report, ambulatory patients—with an alkaline vaginal mucosa resulting from pathogens—maintained an acid vaginal mucosa of pH 3.5 for 4 to 6 hours after douching with Massengill Powder; recumbent patients maintained a satisfactory acid condition up to 24 hours.

Generous samples on request.

The S.E. MASSENGILL Company

Bristol, Tennessee *New York* *Kansas City* *San Francisco*



Vitamin A, one of the 8 essential vitamins in Vi-Penta® Drops, helps to maintain firm tissue, orderly bone growth, and eye health, too, in your infant patients. Just 0.6 cc provides the baby's daily needs... easy to give and easy to take, and dated to assure full potency.

Hoffmann - La Roche Inc · Nutley · N.J.

Check list — for infections in children

Which advantage of Gantrisin (acetyl) Pediatric Suspension is most important to you?

... a wide antibacterial spectrum

... no overgrowth of fungi

... minimized danger of sensitization or emergence of resistant strains

... pleasant flavor without medicine taste

... no alkalies required

All these advantages together have made Gantrisin® Pediatric Suspension "a sulfonamide of first choice for children."

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

GENERAL INFORMATION

THE JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is the official organ of the American Medical Women's Association and is issued monthly the fifteenth of each month.

CONTRIBUTIONS—THE JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION extends an invitation to the profession for articles on original investigation, for reviews, case reports, articles of historical interest—especially those dealing with the status of women physicians, biographies of women in medicine, and any other material on subjects of special concern to women physicians. All manuscripts for pubication, letters, and all communications relating to the editorial management of the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION should be sent to the Editor at the address below.

Articles are accepted for publication with the understanding that they are original contributions never previously published and are contributed solely to the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION. All manuscripts are subject to editorial modification and upon acceptance become the property of the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION. Material published in the JOURNAL is copyrighted and may not be reproduced without permission of the Editor. Neither the editors nor the publisher nor the American Medical Women's Association will accept responsibility for the statements made or opinions expressed by any contributor in any article published in its columns.

MANUSCRIPTS—Manuscripts must be typewritten on one side of the paper only with double spacing and wide margins. The original and one carbon copy should be submitted; a second carbon copy should be retained by the author. The author's full name, academic or professional titles, and complete address must accompany manuscript.

ABSTRACTS—Authors are requested to submit concise abstracts of their papers to the Editor.

ILLUSTRATIONS—Illustrations must be in the form of glossy prints or drawings in black ink. On the back of each illustration the figure number, author's name, and indication of the top of the picture must be given. Legends for illustrations must be typewritten in a single list, with numbers corresponding to those on photographs and drawings. THE JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION encourages the use of illustrations and will supply a reasonable number free of cost; special arrangements must be made with the Editor for excess illustrations or elaborate tables. The Editor is not responsible for the safe return of manuscripts and illustrations. All material supplied for illustrations, if not original, should be accompanied by reference to the source and permission for reproduction from the owner of copyright. Recognizable photographs of patients should carry with them written permission for publication.

REFERENCES—Bibliographic references should appear at the end of the manuscript and not in footnotes. They should conform to style of the Quarterly Cumulative Index Medicus. This requires, in the order given, name of author, title of article, name of periodical, with volume, inclusive pages, month (and day of month if the journal appears weekly), and year. References should be numbered consecutively throughout the paper and listed in order by number from the text.

Galley proofs of scientific articles will be furnished JOURNAL authors for correction. Proofs of other articles will be supplied upon request.

REPRINTS—Reprints of all articles must be ordered at time proof is returned. Prices will be available for quotation from the Business Manager when articles are in page form. Individual reprints of articles must be obtained from the author.

REVIEWS OF BOOKS—Because of limitations of space, only books of scientific interest or reference value which can be recommended to its readers will be noted. All books for review should be sent to the Editor at address below.

SUBSCRIPTIONS—The subscription price of the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is $5.00 per year, $9.00 for two years; single copies are $1.00.

ADVERTISING—Rates will be furnished by the Business Manager of the JOURNAL, 1790 Broadway, New York 19, N. Y. The publishers reserve the right to decline any advertising submitted and to censor all copy. Acceptance of an advertisement does not imply official endorsement of the product advertised.

CHANGE OF ADDRESS—Notification of change of address should be sent to the JOURNAL office, 1790 Broadway, New York 19, N. Y. Please give both old and new addresses.

Address all correspondence to the

JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION

1790 Broadway, New York 19, N. Y.

American Medical Women's Association, Inc.

BRANCH OFFICERS, 1956-1957

ONE, WASHINGTON, D. C.

President: Claudine Moss Gay, M.D., 403 East Capitol, Washington 2, D. C.

Secretary: Vita Jaffee, M.D., 6301 W. Halbert Road, Bethesda, Maryland.

Meetings held first Tuesday, October to May.

TWO, CHICAGO, ILLINOIS

President: Elizabeth R. Fischer, M.D., 10401 S. Bell Ave., Chicago, Illinois.

Secretary: Mary Stephens, M.D., 55 East Washington St., Chicago, Illinois.

Meetings held monthly.

THREE, MARYLAND

President: Grace Hiller, M.D., Goucher College, Towson 4.

Secretary: Mary Matthews, M.D., 8106 Harford Rd., Baltimore 14.

Membership Chairman: Pearl L. Scholz, M.D., 11 Blythewood Road, Baltimore 10, Md.

Meetings held first Thursday of month.

FOUR, NEW JERSEY

President: Ruth Kidd, M.D., 1199 Morris Ave., Union.

Secretary: Gertrude Ash, M.D., 866 South 13th St., Newark.

Membership Chairman: Ella Coughlan, M.D., 10 Oakwood, Orange.

FIVE, PORTLAND, OREGON

President: Miriam Luten, M.D., 308 Taylor St. Bldg., (919 Taylor Street) Portland 5.

Secretary: Dorothy Vinton, M.D., 2455 N.W. Marshall, Suite 5, Portland 10.

Dinner meetings held every two months, with a symposium on scientific topics of general interest.

SIX, OMAHA, NEBRASKA

President: Aileen Mathiasen-Sciortino, M.D., 6 Hall St., Council Bluffs, Iowa

Secretary: Louise M. Camel Farrage, M.D., 478 Elmwood, Council Bluffs, Iowa

EIGHT, NEW ORLEANS, LOUISIANA

President: Georgiana J. von Langermann, M.D., 1430 Tulane Avenue, New Orleans.

TEN, WISCONSIN

President: Elaine Pedersen, M.D., 6040 West Lisbon Ave., Milwaukee.

Secretary-Treasurer: Mary Hall, M.D., 4042 North Wilson Drive, Milwaukee.

ELEVEN, SOUTHWESTERN OHIO

President: Gail Englander, M.D., 3729 Reading Road, Cincinnati 29.

Secretary: Emily Wright, M.D., 42 Burns Avenue, Cincinnati 15, Ohio

Meetings held second Tuesday, September, November, January, March, May.

TWELVE, COLUMBUS, OHIO

President: Dorothy F. Falkenstein, M.D., 188 E. State St., Columbus.

THIRTEEN, SAN DIEGO, CALIFORNIA

President: Mary Fishel, M.D., 4752 Palm Ave., La Mesa.

Secretary: Margaret Siems, M.D., 233 A St., San Diego.

Meetings held every other month on fourth Thursday.

FOURTEEN, NEW YORK, NEW YORK

President: Adelaide Romaine, M.D., 35 West 9th St., New York 11.

Secretary: Margaret S. Tenbrinck, M.D., 235 East 22nd St., New York 10.

Membership Chairman: Estelle DeVito, M.D., 301 East 21st St., New York 10.

FIFTEEN, CLEVELAND, OHIO

President: Viola Startzman, M.D., 2020 E. 93 Street, Cleveland 6

Secretary: Kathryn Hoffman, M.D., Schoffield Bldg., Cleveland

SIXTEEN, PITTSBURGH, PENNSYLVANIA

President: Virginia E. Washburn, M.D., 4403 Center Avenue, Pittsburgh 13.

Secretary: Marita Kenna, M.D., 4740 Liberty Avenue, Pittsburgh 24.

EIGHTEEN, NEW YORK STATE

President: Anna P. Walsh, M.D., 391 Jersey Street, Buffalo 4.

Secretary: Harriet Hosmer, M.D., 333 Linwood Avenue, Buffalo 9.

Membership Chairman: Marguerite P. McCarthy-Brough, M.D., 1811 West Genessee Street, Syracuse.

NINETEEN, IOWA

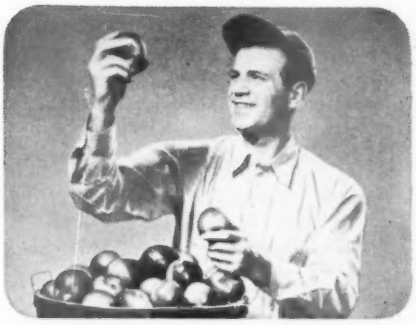
President: Nelle Shultz, M.D., 106 North Taft St., Humboldt.

Secretary: Jean Glissman, M.D., 1068 42nd St., Des Moines.

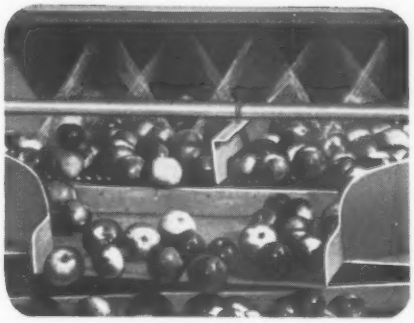
Meetings held each April, in conjunction with state medical meeting.

(Continued on page 20)

WHAT BEECH-NUT QUALITY MEANS



FRESHNESS in every jar. Fruits and vegetables are picked at perfection and processed to provide the most in eating pleasure.



PURITY is guarded all the way by Beech-Nut —from the careful washing of every ingredient, to the sterilization of each sparkling glass jar.

FLAVOR is constant. A panel of taste testers makes daily checks to positively guarantee Beech-Nut's uniformly fine flavor.

NUTRITION is another important factor in Beech-Nut quality. Precious vitamins and minerals have been retained in high degree.

VARIETY is the spice of Baby's life with Beech-Nut. There are 5 pre-cooked Baby Cereals, 28 Strained Foods, 26 Junior Foods.

Pediatricians know that Beech-Nut keeps up with the very latest scientific methods developed for taking better care of Baby. Also, the research department at Beech-Nut is continually searching for new ways to improve packaging, to guarantee important flavor control, to preserve all possible nutritional value. It's no wonder doctors recommend Beech-Nut Baby Foods to mothers for their babies.

Beech-Nut Baby Foods

American Medical Women's Association, Inc.

BRANCH OFFICERS, 1956-1957—(Continued)

TWENTY (BLACKWELL), DETROIT MICHIGAN

President: Carol Platz, M.D., 11368 Kelly.

Secretary: Kathryn O'Connor, M.D., 14301 Grand River.

Meetings held five times a year.

TWENTY-THREE, LOS ANGELES, CALIFORNIA

President: Mary B. Dale, M.D., 1035 E. Howard Street, Pasadena.

Secretary: Louise Geise, M.D., 940 Arden Road, Pasadena.

Membership Chairman: Elizabeth Mason-Hohl, M.D., 1234 Vermont Avenue, Hollywood.

TWENTY-FOUR, KANSAS

President: Mary T. Glassen, M.D., Phillipsburg.

Secretary: Ruth P. Spiegel, M.D., Formosa.

Next meeting will be held on call.

TWENTY-FIVE, PHILADELPHIA, PENNSYLVANIA

President: Mary D. Varker, M.D., 604 Sussex Road, Wynnewood.

Secretary: Marjory A. Meyer, M.D., 916 Edmonds Avenue, Drexel Hill.

Meetings held three times a year.

TWENTY-SIX MINNESOTA

President: Della G. Drips, M.D., Oronoco.

Secretary: Nellie N. Barsness, M.D., 540 Lowry Medical Arts Bldg., St. Paul.

TWENTY-NINE, ATLANTA, GEORGIA

President: Vernelle Fox, M. D., 1293 W. Peachtree Street, N.W., Atlanta.

Secretary: Eleanor Bundy, M. D., 706 Church Street, Decatur.

Membership Chairman: Virginia Tuggle, M.D., 822 Columbia Drive, Atlanta.

Meetings held third Saturday, alternate months.

THIRTY, UPPER CALIFORNIA

President: Jane Schaefer, M.D., 490 Post St., San Francisco.

Secretary: Eleanor Brown, M.D., 22 Terra Vista, San Francisco.

THIRTY-ONE, MISSISSIPPI

President: Eva L. Meloan, M.D., 964 N. State St., Jackson.

Secretary: Ruth R. Burroughs, M.D., 2912 N. State St., Jackson.

THIRTY-TWO, WESTERN NORTH CAROLINA

President: Irma Henderson-Smathers, M.D., 1295 Merriman Ave., Asheville.

Secretary: Louise Galloway, M.D., 25 Arthur Rd., West Asheville.

Membership Chairman: Ethel Brownsberger, M.D., 75 Hendersonville Rd., Biltmore, N.C.

THIRTY-THREE, FLORIDA

President: Mary C. Patras, M.D., 8340 N.E. Second Ave., Miami 38.

Secretary: Minerva Gordon, M.D., 541 Lincoln Road, Miami Beach.

THIRTY-FOUR, ARKANSAS

President: Elizabeth D. Fletcher, M.D., 705 Donoghey Bldg., Little Rock.

Secretary: Martha M. Brown, M.D., State Hospital, Little Rock.

THIRTY-FIVE, PUERTO RICO

President: Alice Reinhardt, M.D., Santorio Insula, Rio Piedros.

Secretary: Maria Amelia Pares, M.D., Professional Building, Santurce.

THIRTY-SIX, ALAMEDA COUNTY, CALIFORNIA

President: Miriam Rutherford, M.D., 2929 Summit St., Oakland

Secretary: Dorothy McDonald, M.D., 2490 Channing Way, Berkeley.

THIRTY-SEVEN, SEATTLE, WASHINGTON

President: Phyllis Leibly, M.D., 4530-51st St., N.E., Seattle.

Secretary: Lily E. Schoffman, M.D., 828 Fourth and Pike Bldg., Seattle.

THIRTY-EIGHT, LONG BEACH, CALIFORNIA

President: Mary Callaghan, M.D., 384 Redondo Ave., Long Beach.

Secretary: Primitiva Demandante, M.D., 908 North Avelon Blvd., Wilmington.

THIRTY-NINE, BOSTON, MASSACHUSETTS

President: Victoria Cass, M.D., 4 Myopia Road, Winchester.

Secretary: Marian W. Perry, M.D., 88 Scotland Road, Reading.

Membership Chairman: Mary I. Tompkins, M.D., 1108 Beacon St., Brookline 46.

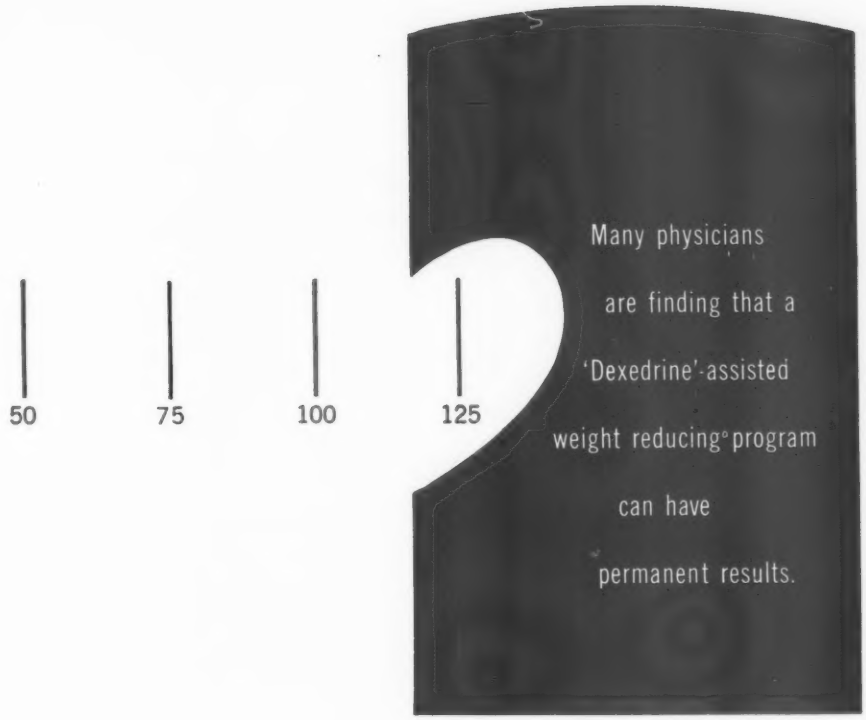
FORTY, DALLAS, TEXAS

President: Katharine Bennett, M.D., 915 St. Joseph, Dallas, Texas.

Secretary: Harriet Rogers, M.D., 4307 Camden, Dallas, Texas.

(Continued on page 30)

Please report all changes in Branch officers and chairmen as soon as possible to American Medical Women's Association, 1790 Broadway, New York 19, New York.



'Dexedrine' not only curbs appetite during weight reduction therapy, but also helps maintain weight loss. While on 'Dexedrine' therapy, the patient becomes accustomed to a lowered food intake. When 'Dexedrine' is withdrawn, the adjustment to new eating habits made with 'Dexedrine' ordinarily persists.

Dexedrine* Sulfate
(dextro-amphetamine sulfate, S.K.F.)
Tablets • Elixir • Spansule† capsules

made only by
Smith, Kline & French Laboratories, Philadelphia
first ⧗ in sustained release oral medication

*T.M. Reg. U.S. Pat. Off.
†T.M. Reg. U.S. Pat. Off. for sustained release capsules, S.K.F.
Patent Applied For

ACHROMYCIN

Tetracycline *Lederle*

in the treatment of

infections in surgery

The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

For example, Albertson and Trout[1] have reported successful results with tetracycline (ACHROMYCIN) in diverticulitis, gangrene of the gall bladder, tubo-ovarian abscess, and retropharyngeal abscess. Prigot and his associates[2] used tetracycline in successfully treating patients with subcutaneous abscesses, cellulitis, carbuncles, infected lacerations, and other conditions.

As a prophylactic and as a therapeutic, ACHROMYCIN has shown its great worth to surgeons, as well as to internists, obstetricians, and physicians in every branch of medicine. This modern antibiotic offers rapid diffusion and penetration, quick development of effective blood levels, prompt control over a wide range of organisms, minimal side effects. There are 21 dosage forms to suit every need, every patient, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Broad-range antibiotic action to fight infection; important vitamins to help speed normal recovery. In *dry-filled, sealed* capsules for rapid and complete absorption, elimination of aftertaste.

dry-filled sealed capsules

[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

Lederle

LEDERLE LABORATORIES DIVISION

AMERICAN CYANAMID COMPANY

PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

PHOTO DATA: AERIAL CAMERA WITH K-2 FILTER AT DUSK, F.11, 4/100 SEC., FAST PAN FILM

ACHROMYCIN ACHROMYCIN

JUNIOR BRANCH OFFICERS, 1956-1957

UNIVERSITY OF ALABAMA

President: Maude Dieseker, 800 South 20th St. Birmingham, Alabama.

Secretary: Betty Jean McBride, 800 South 20th Street, Birmingham, Alabama.

Sponsor: Evelyn L. Stansell, M.D., 314 N. 15th Street, Bessemer, Alabama.

UNIVERSITY OF ARKANSAS

President: Betty Ann Lowe, University of Arkansas School of Medicine, Little Rock, Arkansas.

Secretary: Betty Jane McClellan, 222 West "G" Street, Park Hill, North Little Rock, Arkansas.

Sponsor: Eva Dodge, M.D., University of Arkansas School of Medicine, Little Rock, Arkansas.

BAYLOR UNIVERSITY

President: Elizabeth Muchmore, 1903 Portsmouth, Houston, Texas.

Secretary: Betsy Comstock, Baylor University College of Medicine, Houston, Texas.

Sponsor: Ruth Hartgraves, M.D., 1407 Medical Arts Bldg., Houston, Texas.

ESTHER C. MARTING JUNIOR BRANCH, CINCINNATI, OHIO

Persident: Cornelia Dettmer, 2991 Werk Road, Cincinnati, Ohio.

Secretary: Virginia Beamer, 351 Erkendrecher Avenue, Cincinnati.

Sponsor: Esther C. Marting, M.D., 2314 Auburn Avenue, Cincinnati, Ohio.

MEDICAL COLLEGE OF GEORGIA

President: Nelle Strozier, Medical College of Georgia, University Place, Augusta.

Secretary: Sara L. Goolsby, Medical College of Georgia, University Place, Augusta.

Sponsor: B. Shannon Gallaher, M.D., Medical College of Georgia, University Place, Augusta, Georgia.

HAHNEMANN MEDICAL COLLEGE

President: Audrey Krauss, 300 South Camas Street, Philadelphia, Pennsylvania.

Secretary: Patricia Cusick, Hahnemann Medical College, Philadelphia, Pennsylvania.

Sponsor: Elizabeth B. Brown, M.D., 1930 Chestnut Street, Philadelphia, Pennsylvania.

HOWARD UNIVERSITY

President: Sara Ewell, Wheatley Hall, Howard University, Washington, D.C.

Secretary: Z. Ozella Thompson, 5345 Bell Place, Washington 1, D.C.

NORTHWESTERN UNIVERSITY

President: Marianne Whowell, 2118 N. Sedgwick, Chicago, Illiois.

Secretary: Frances Taylor, 1160 N. State Street, Chicago, Illinois.

Sponsor: Beulah Cushman, M.D., 25 E. Washington, Chicago, Illinois.

FLORENCE SABIN JUNIOR BRANCH, UNIVERSITY OF COLORADO

President: Yvonne Johnson, 1163 Lincoln, Boulder, Colorado.

Secretary: Nancy Nelson, 740 Fourth Avenue, Longmont, Colorado.

Sponsor: Gertrude Weiss, M.D., 4200 E. Ninth Avenue, Denver 20, Colorado.

UNIVERSITY OF UTAH

President: Frances R. Beier, 3396 E 3900 South, Salt Lake City, Utah.

Secretary: Mary Gehres, 233 Douglas Street, Salt Lake City, Utah.

Sponsor: Camilla Anderson, M.D., 239 Virginia Street, Salt Lake City, Utah.

GEORGE WASHINGTON UNIVERSITY

President: Roberte Raymond, 2010 Kalorama Road, N.W., Washington, D.C.

Secretary: Diane Perrine, 2010 Kalorama Road, N.W., Washington, D.C.

Sponsor: Elizabeth S. Kahler, M.D., 3828 Fulton Street, N.W., Washington, D.C.

new

Against Pathogen & Pain

in urinary tract infections

Azo Gantrisin combines the single, soluble sulfonamide, Gantrisin, with a time-tested urinary analgesic - in a single tablet.

Prompt relief of pain and other discomfort is provided together with the wide-spectrum antibacterial effectiveness of Gantrisin which achieves both high urinary and plasma levels so important in both ascending and descending urinary tract infections.

Each Azo Gantrisin tablet contains 0.5 Gm Gantrisin 'Roche' plus 50 mg phenylazo-diamino-pyridine HCl.

Gantrisin® - brand of sulfisoxazole

ROCHE | Original Research in Medicine and Chemistry

allergic to pollen
. . . yet fully enjoying summertime

Lilly
QUALITY/RESEARCH/INTEGRITY
656031

'Co-Pyronil'

(PYRROBUTAMINE COMPOUND, LILLY)

. . . usually eliminates distressing symptoms without causing side-effects; allows the allergic patient to enjoy fully this "funtime" season of the year.

rapid-acting . . . relief usually noted within fifteen to thirty minutes.

long-acting . . . relief often maintained for eight to twelve hours; thus continuous relief is provided on a convenient dosage schedule.

complete relief . . . more frequently obtained because of the complementary actions of two antihistamines and a sympathomimetic.

Supplied as pulvules, pediatric pulvules, and suspension. Also, Tablets 'Pyronil' (Pyrrobutamine, Lilly), 15 mg.

prescribe relief from allergy . . . prescribe 'Co-Pyronil'

80TH ANNIVERSARY 1876 · 1956 / ELI LILLY AND COMPANY

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

VOLUME 11 JULY 1956 NUMBER 7

The Control of Poliomyelitis

A. M.-M. Payne, M.D., M.R.C.P.

INFANTILE PARALYSIS is as old as history. Typical examples of the results of this disease can be seen in ancient Egyptian sculptures, yet it was not until a little more than a hundred years ago that the condition was recognized as an entity, and it was only within the last sixty or seventy years that it was recognized as an infectious disease.

In 1907, Wickman[1] stated clearly that poliomyelitis was a contagious disease spread both by typical and abortive cases, and by healthy carriers. Soon after this, Landsteiner,[2] by transmitting the disease to monkeys, showed that it was caused by a virus. It was therefore entirely logical that measures used to control many other contagious diseases should be proposed for the control of poliomyelitis. In 1911, Flexner [3] advocated quarantine measures both for the patient and his attendants. He emphasized the safe disposal of bodily excretions and also suggested that flies might be important in the spread of the disease.

In the years that followed, numerous publications re-emphasized and expanded these recommendations to include notification of the disease; quarantine of the family; placarding; fumigation; investigations into milk, water, and food supplies to ensure their safety; prohibition of public gatherings, especially of children; postponement of openings of schools; and restriction of movements into and out of infected areas. Such measures were more or less strictly applied, but it must be confessed that there was little or no objective information on which an assessment of their value could be placed. Indeed, the general verdict of health officers was that these measures were of little use.

In the years after World War I, no real progress was made towards the control of the disease. Indeed, the disease became more widespread and epidemics more frequent. Laboratory research was severely handicapped by the fact that at this time only primates could be infected with the virus; the fact that they could be infected by the instillation of material into the nose led many epidemiologists to conclude that in man the disease was predominantly transmitted by the respiratory route. Since control of diseases transmitted in this way is notoriously difficult, this theory may have been responsible for a casual attitude.

Following the discovery by Armstrong [4] in 1939 that type 2 virus (Lansing) could be adapted to mice, there were hopes of more rapid progress in understanding the epidemiology of the disease. These hopes were to some extent fulfilled by the studies of Paul [5] and others who demonstrated that infection with this virus was widespread in areas where clinical disease was rarely recognized. The rather surprising fact emerged that the incidence

Dr. Payne is Chief of the Endemo-Epidemic Diseases Section, World Health Organization, Geneva, Switzerland.

of clinical disease seemed to bear an inverse relationship to the incidence of infection. This apparent contradiction is not fully understood. There appear to be two probable reasons, both of which may be partly responsible. The first is based on the fact that the mean incidence of paralytic poliomyelitis over a number of years appears to increase as the hygiene and sanitation of a country improves. At the same time, more and more children of older ages are affected, and eventually as much as one third of all cases may be over the age of 15. Serologic surveys have confirmed that this delayed infection does, in fact, happen; further, certain studies have indicated that the probability of paralysis resulting from an infection with the poliovirus in non-immune people increases with increasing age. According to this explanation, in countries where the infection is widespread and occurs in the great majority of children in infancy, paralysis will result less often than in countries where the infection is less widespread and is delayed until school age or after. However, Sabin [6] has shown that it is not possible to explain all the facts in this way because the difference in incidence of paralysis after infection in the different age groups is not sufficient to account for the difference in incidence of paralysis in countries of greatly different levels of social and economic development.

The other reason is that there may be varieties of poliovirus which are relatively avirulent and therefore less likely to cause paralysis after infection. There is now conclusive evidence that such viruses exist; they have been recovered from symptomless persons and have also been evolved by passage in the laboratory. According to this theory, many of the viruses causing widespread infection in countries with poor hygiene and sanitation are of relatively low virulence and rarely cause paralysis. However, again it is not possible to explain all the facts on the basis of this theory alone. There was abundant experience during and after World War II proving that some of the viruses in these areas are, in fact, fully virulent, for the incidence of poliomyelitis in soldiers coming from countries where hygiene and sanitation were highly developed was often much higher when they were sent to tropical countries than it was in their native countries.

It is evident from this brief outline that there are many factors in the epidemiology of poliomyelitis which we do not yet understand; it is also evident that the mere application of sanitary measures which have proved to be highly effective in controlling other alimentary infections, such as typhoid fever, are of little value in the control of poliomyelitis. In fact, they seem in the past to have done more harm than good since their main effect has been to delay infection to an age at which it is more liable to produce paralysis. I shall, however, return to this point a little later since there are now circumstances in which sanitary measures may have a place in the control of poliomyelitis.

Since non-specific control measures have shown themselves ineffective, it is natural that scientists should turn to specific measures in an attempt to control the disease. A vaccine against poliomyelitis was tried out in the 1930's, but for various reasons this ended in disaster and further progress was delayed for many years.

It was not until extensive studies were sponsored by the National Foundation for Infantile Paralysis following World War II that any real progress was made. Perhaps the first important step was the extensive typing studies undertaken by the Foundation. They showed conclusively that we had to deal with not one virus but three distinct immunologic types. Then came the great discovery of Enders, Weller and Robbins [7] that poliovirus could be grown in tissue culture. This discovery revolutionized completely prospects for the future. It not only enabled us to undertake extensive studies in the epidemiology of the disease and its pathogenesis, but also, in conjunction with the work of Morgan, Morton and Parker,[7a] who developed a synthetic medium suitable for the growth of poliovirus, opened the prospect of the production of a vaccine against poliomyelitis of a purity unapproached by almost any other vaccine.

As is now well known, the development of this vaccine was undertaken by Dr. J. E. Salk, aided by the National Foundation for Infantile Paralysis. He and his associates, in a long series of studies, have worked out methods of producing suspensions of poliovirus suitable for the preparation of an inactivated vaccine. This work was brought to a triumphant conclusion in the greatest field trial in the history of medicine [8] in which it was shown that the vaccine was both safe and effective. Immediate steps were taken to apply the vaccine in the United States on a large scale, and preparations to do the same were also made in a number of other countries. Probably never in medical history has a new public health measure been applied so rapidly on a mass scale after the painstaking laboratory research which led to its development. It was almost inevitable, therefore, that this transition should be attended by serious difficulties. These events are so fresh in our minds that they need not be enlarged upon here. However, considerable confusion resulted both among the general public and among health authorities. Many of the latter found it diffi-

cult to decide whether or not they should take steps to bring the new control methods into general use, and, if so, what these steps should be.

During the late spring, summer, and autumn of 1955, the vaccine was used on a large scale in the United States, Canada, and Denmark, and on a smaller scale in Germany, and the Union of South Africa. In November 1955, therefore, the time seemed opportune for the World Health Organization to call a meeting in Stockholm of leading experts from nine countries to review the experience of each in the use of the vaccine. In addition to exchanging views and experiences, the group was able to define some oustanding problems and to plan co-ordination of further research. The report of the meeting[9] presents some essential facts and important recommendations which have already proved of service in enabling the governments of several countries to formulate their policies concerning poliomyelitis vaccination.

Suffice it to say that apart from about 200 vaccine-associated cases of poliomyelitis, many millions of children have been vaccinated; evidence is accumulating that this has been of real value in reducing the incidence of paralytic poliomyelitis. There is now good reason to believe that the "teething troubles" of large-scale production have been solved and that all the necessary precautions are taken to ensure a consistently safe and effective product.

WHO's programme for the study of poliomyelitis was developed after an Expert Committee meeting in 1953,[10] and has been designed to give some of the epidemiological information needed for the proper application of vaccination. A network of WHO regional poliomyelitis laboratories have now been designated in all regions, and national laboratories are being encouraged to co-operate in a co-ordinated programme. The problems that are being studied include the improvement of national reporting systems, the provision of standard sera and strains of virus, the study of the prevalent viruses in different regions, the design of standard methods of survey to determine the state of immunity of populations, the supply of scarce materials needed for tissue culture work, and the training of virologists in laboratory techniques. Surveys had already been completed, or were under way, at the end of 1955 in several countries in Europe, the Americas, and Africa.

It will be some time before we can answer outstanding questions regarding the effectiveness of the Salk vaccine in age groups other than those in which it has been proved effective. We must wait to discover how long immunity will last and how often reinforcing doses may be needed. We must also watch carefully for the effect that its widespread use may have on the epidemiology of poliomyelitis, since experience in others fields has shown us that interference with natural processes on a large scale may lead to unexpected side-effects, not easy to foresee and sometimes unpleasant. This may not arise but we must maintain vigilance.

Morning conference concerning child with poliomyelitis, Israel.

Recognition of the theoretical advantages of adapting natural processes to our own ends has led many scientists to believe that the final conquest of poliomyelitis may be achieved in a different way. I have already pointed out that there are large areas of the world where poliomyelitis infection is widespread but where paralysis is rare. In these areas, the balance between infection and immunity may be considered at present to be almost as favourable as we have been able to achieve by artificial means in many other infectious diseases. We have seen that this balance appears to depend on the dissemination of relatively avirulent viruses among infants at a very early age. If we imitate this natural process artificially, we may be able to achieve the same results, or even to improve upon the natural balance, because we may be able to ensure that all the viruses disseminated are of very low virulence, although in nature some of them are fully virulent.

It is evident that the dissemination of living viruses, even though they may be shown to be

of low virulence in the laboratory, is not a measure which can be undertaken lightly. Prolonged and painstaking research will be necessary to ensure that we can do this with safety. Sabin,[6] Koprowski[11] and his colleagues, and others, have already made progress in this field. It would be unwise at this early stage to make any prophecies as to outcome.

Earlier, I indicated that I would again refer to the place of hygienic measures in the control of poliomyelitis. We now have a vaccine which is effective, but not 100 percent effective. Cases occur even among vaccinated children and we must do our best to prevent them. Recent epidemiological studies have indicated that in highly developed communities, poliomyelitis infection may be concentrated in a relatively narrow stream comprising cases and their family contacts, particularly children, and to a lesser extent close extra-familial contacts; on the other hand, there may be little infection in non-contacts in the same neighbourhood. It would therefore appear that under these circumstances, quarantine measures concentrated around the close contacts of cases might diminish significantly the distribution of infection and so prevent a number of cases. That such measures have seemed to be ineffective when applied on a large scale in the past need not deter us. By analogy with what is found in countries less highly developed in their sanitation and hygiene now, it is not unreasonable to assume that infection was widely disseminated even in the most highly developed countries twenty to thirty years ago. Furthermore, the temporary prevention of early infection twenty to thirty years ago only resulted in infection being delayed until, as has already been pointed out, it would be more likely to produce paralysis. This situation is not the same today, since we have a means of artificial immunization. Thus the apparent deleterious effect of sanitary measures on the incidence of paralysis need no longer be feared.

There are further measures we can take in the prevention of paralysis in those patients not completely protected by vaccination. In the past few years, it has been shown that there are certain provoking factors which increase the probability of paralysis resulting from poliomyelitis infection. The most important of these appear to be the effect of certain injections, particularly intramuscular injections, over-exertion during certain stages of the disease, and hormonal changes, such as pregnancy.

There is now no doubt that certain injections will not only cause localization of the paralysis in the injected limb but will also actually increase its frequency. This can occur only in the presence of poliomyelitis infection. A valuable preventive measure, therefore, is the avoidance of these injections during times of prevalence of poliomyelitis infection. We need further information as to the effect of vaccination on the incidence of infection and non-paralytic poliomyelitis, but the indications are that infection is not prevented, and non-paralytic poliomyelitis is not reduced in frequency, by poliomyelitis vaccination. The same precautions should therefore by taken for vaccinated as for non-vaccinated children.

Other observations have indicated that over-exertion during the illness known as non-paralytic poliomyelitis may in some instances be responsible for the precipitation and exacerbation of paralysis. Where non-paralytic poliomyelitis is suspected, therefore, even in a vaccinated child, it would be wise to ensure complete rest until the illness is past. Furthermore, it should be recognized that, as far as we know at present, these children are infectious. They therefore may be of danger to uninfected persons who are not already naturally immune.

It is now generally accepted that pregnancy gives rise to a special risk of paralysis following poliomyelitis infection. This is especially important in highly developed countries where a considerable proportion of young adults may still be fully susceptible to the disease. In many countries, therefore, priority has been given for the vaccination of pregnant women.

Another precipitating factor which is widely recognized is that tonsillectomy, and possibly dental extractions, are particularly liable to be followed by bulbar poliomyelitis if the infection is present. This can readily be avoided by carrying out such procedures, except in an emergency, at a time when poliomyelitis is not prevalent. However, it has recently been shown that there appears to be an increased liability to the bulbar form of the disease in persons who have had their tonsils removed even several years before. Fortunately, vaccination appears to be particularly effective in preventing the bulbar form of the disease. However, this observation must be taken into consideration with the other indications for the removal of tonsils.

It has not been possible in this brief article to cover all the problems of the control of poliomyelitis, nor to mention the many important observations which have brought us so far along the road to success. A much more detailed study can be found in the WHO Monograph No. 26 on Poliomyelitis. That we are now along the road to success there can indeed be no doubt, but many years of patient observation will be needed before we can conclude that poliomyelitis is finally beaten.

REFERENCES

[1]Wickman, O. I., Beitrage zur kenntnis der Heinemedinsche krankheit (poliomyelitis acuta und verwandter erkrankungen), Berlin, S. Karger, 1907.

[2]Landsteiner, K., and Levaditi, C., La transmission de la paralysie infantile aux singes, Compt. rend. Soc. de biol., Paris **67:** 592-594, '09.

[3] Flexner, S., Control of epidemic poliomyelitis, Am. J. Dis. Child. **2:**96-101, Aug. '11.

[4] Armstrong, C., Successful transfer of Lansing strain of poliomyelitis virus from cotton rat to white mouse, Pub. Health Rep. **54:**2302-2305, Dec. 29, '39.

[5] Paul, J. R., Epidemiology of poliomyelitis, in WHO Monograph No. **26:** Poliomyelitis, 1955, pp. 9-29.

[6] Sabin, A. B., Immunity in poliomyelitis, with special reference to vaccination, in WHO Monograph No. **26:** Poliomyelitis, 1955, pp. 297-334.

[7] Enders, J. F., Present status of tissue-culture techniques in study of poliomyelitis viruses, in WHO Monograph No. **26:** Poliomyelitis, 1955, pp. 269-294.

[7a]Morgan, J. F., Morton, H. J., and Parker, R. C., Nutrition of animal cells in tissue culture; initial studies on synthetic medium, Proc. Soc. Exper. Biol. & Med. **73:** 1-8, Jan. '50.

[8]Vaccine Evaluation Center, Evaluation of 1954 field trial of poliomyelitis vaccine, Univ. of Mich., Ann Arbor, 1955.

[9] WHO Techn. Rep. Series No. 101, Poliomyelitis Vaccination, Feb. 1956.

[10] WHO Techn. Rep. Series No. 81, Poliomyelitis, April 1954.

[11]Koprowski, H., Immunization of man with living poliomyelitis virus, in WHO Monograph No. **26:** Poliomyelitis, 1955, pp. 335-356.

International Quarantine

Yves Biraud, M.D., M.P.H.

LONG BEFORE THEY UNDERSTOOD how epidemic diseases spread, men recognized their communicable character and tried to keep them from entering their cities. In 1423, Venice set the pattern for island quarantine lazarets, where ships suspected of carrying plague from the Levant could anchor at a safe distance from the town. In spite of its many failures, the system was copied by other ports in the ensuing centuries.

Thus protection against invasion by pestilential diseases from abroad was the first object of organized public health, and the first health services to be established were quarantine services. They often served as the nucleus around which grew the national health department. In the United States, the U. S. Public Health Service is an outgrowth of the U. S. Maritime Quarantine Service, which explains the association on its official seal of the anchor and chain with the caduceus. International health institutions also have their origin in quarantine.

The failure of the most rigorous quarantine measures taken independently by the countries of Europe to protect the Continent from invasion by both yellow fever and cholera showed the need for co-ordination of effort as well as unity of purpose.

Since the first International Sanitary Conference was held in Paris in 1851, efforts at international organization became increasingly frequent and effective. Quarantine boards of a semi-international character were established in Istanbul in 1839 and in Alexandria in 1892 to control the spread of cholera and plague by shipping passing through the Straits and the Suez Canal respectively. In America, the Pan American Sanitary Bureau was set up to co-ordinate action against yellow fever. Finally, in 1908, the International Public Health Office was established in Paris to set up international quarantine agreements to control the spread of all pestilential diseases throughout the whole world.

It was similarly the menace of the invasion of Central and Western Europe by the tremendous epidemics of typhus and relapsing fevers which raged in the USSR in 1922 which inspired the setting up by the League of Nations of its Epidemic Commission and of its Health Organisation shortly after. It is significant also that, in 1943, one of the first actions of the United Nations Relief and Rehabilitation Administration was to draft fresh international sanitary conventions. Eventually, the PASB, the Paris Office, and the Health Organisation of the League extended their interest and activities to communicable diseases other than the

Dr. Biraud is Director of Epidemiological Services, World Health Organization, Geneva, Switzerland.

pestilential ones and to the more positive forms of public health work such as rural hygiene, nutrition, and so forth, but each of them retained its original quarantine functions.

In July 1946, when the World Health Organization came into being, through a merger of all pre-existing international health institutions, the first unit to operate was that of quarantine together with its necessary adjunct, a service of epidemiological intelligence.

Looking back at the past century of international efforts towards the prevention of the spread of disease from country to country, and at the groping national endeavours which preceded them, it becomes clear that success could not be achieved until modern scientific knowledge of the etiology of communicable diseases was available, together with international co-operation to put this knowledge into coherent action. The epidemic scourges of the nineteenth century, the repeated invasions of the European, American, and African continents by Asiatic cholera, the invasion of North America and Southern Europe by yellow fever, and the worldwide pandemic of plague which, in the late nineties, originated in Southern China, were all owing to the fact that progress in transportation had preceded progress in medical knowledge and public health practice.

The discovery of the cholera vibrio by Koch in 1888, of the plague bacillus by Yersin in 1894, and of the transmission of yellow fever by *Aëdes aegypti* by Carlos Finlay in 1901, paved the way for the International Sanitary Conventions of 1903 and 1912. The discovery by Charles Nicolle of the role of the body louse as a transmitter of typhus fever allowed this disease to be effectively covered by the 1926 Sanitary Convention.

The International Sanitary Conventions were international treaties which laid down the measures which parties undertook to carry out, but not to exceed, in order to prevent international transmission of pestilential diseases. Notification of the outbreaks of these diseases was one of these measures. The notifications were formerly issued by the infected country to local consular officers and transmitted through diplomatic channels. They could hardly be carried fast enough and distributed widely enough to allow quarantine measures to be taken in time and withdrawn without excessive delays. Some progress was achieved with the establishment of the International Public Health Office in Paris, which allowed centralization; but it was only when diplomatic channels were replaced by telegraphic communications from and to the national health administrations that notifications became effective. The League of Nations introduced the use of systematic weekly cables on the health situation in several hundred ports in eastern waters and of the regular weekly broadcast of the information thus collected by its Eastern Bureau in Singapore.

The International Sanitary Conventions, being treaties, required ratification by parliaments, which took so much time that a fresh convention would sometimes be launched before ratification of the former was general. There resulted such a confusion of mutual obligations between States participating or not in the various conventions that their application became difficult. That is why one of the earliest activities of WHO was to prepare, by consulting a series of expert committees, regulations which would unify international quarantine practice and bring it into conformity with modern progress in science and travel.

In 1951, the first International Sanitary Regulations were adopted by the World Health Assembly, and became applicable the following year in all the countries which, during a specified period of nine months, had not formally notified the Organization of their rejection of them, or of reservations to certain articles. The WHO Regulations ensured uniformity and simplification of practice which had never previously been achieved. Amendments to the regulations to meet changing conditions may be adopted by the World Health Assembly and become applicable in the same manner after a specified period of time without submitting them to the cumbersome and lengthy process of ratification by all the parliaments of the world.

The regulations define the measures that may be applied by national quarantine services for protection against plague, cholera, smallpox, yellow fever, and louse-borne typhus and relapsing fevers. The measures specified in the regulations, whether vaccination, detention, or surveillance of passengers, disinsectisation, disinfection of their effects and of certain cargoes, and so forth, are specified and may not be exceeded. They may, however, be dispensed with by countries that consider themselves safe. Thus a country where cold weather could not allow survival of *Aëdes aegypti* may well dispense with measures against yellow fever. Measures can be taken only against arrivals from local infected areas, not whole countries or continents. Again, the measures must be withdrawn as soon as the local areas have become decontaminated and the danger has ceased. The measures must interfere as little as possible with international traffic, and since they are taken for the protection of the country of arrival, they cannot be a source of financial profit to that country at the expense of international

travellers or shipping, through the requirement of sanitary dues, taxes, or bills of health.

An international traveller coming from a local area infected with a quarantinable disease must, on arrival in a country receptive to that disease, produce evidence in the form of a valid international certificate of vaccination that he is effectively protected against the said disease, failing which he may be submitted to vaccination and to isolation until the establishment of immunity following vaccination or until the period of incubation of the disease to which he has been exposed is completed. It is therefore very much in his interest to be in possession of all the required vaccination certificates before he actually begins his journey. If an individual not only passes through, but stays in, a foreign country, he becomes subject to the national legislation, which may require him to submit to other vaccinations to ensure his own protection. Thus some countries in which cholera or typhoid are endemic require vaccination against these diseases from people coming from areas not infected with them. This is the reason why air and steamship companies often require intending passengers to submit to vaccinations in excess of the requirements of the International Sanitary Regulations applicable to "international travellers."

It must be noted that the said regulations specify that all countries may require smallpox vaccination certificates of such travellers, irrespective of the infected state, or otherwise, of their place of origin, on account of the fact that all countries and all persons are receptive to smallpox in the absence of vaccination, which is not true for other quarantinable diseases.

In order to limit quarantine measures to passengers and cargoes coming from local infected areas, the medical officers of ports and airports must be kept informed constantly of the distribution of quarantinable diseases throughout the world. They are kept so informed by airmailed copies of the Weekly Epidemiological Record issued by WHO in Geneva, and by its offices in Alexandria, Singapore, and Washington. These publications supplement the daily and weekly epidemiological bulletins which are broadcast by the Organization through a network of 16 wireless stations covering the whole world. These bulletins may be picked up not only by health administrations but also by ships at sea, so that protective measures can be taken before arrival in an infected port.

It must be recognized that while the vast majority of countries provide WHO promptly with notification of outbreaks of quarantinable diseases, others fail to do so because their physicians are too few and their administration insufficient to cover effectively the whole of their territories. This is unfortunate, but in practice it does not jeopardize the international quarantine system seriously, because other countries will regard as potentially infected areas those for which information is not rapidly available, and also because international travel of passengers and goods is practically negligible in and from most of the areas not covered by effective health services and notifications.

In spite of its imperfections, the present international quarantine system has, in recent years, proved its worth by the considerable reduction in the number of outbreaks of cholera, smallpox, and plague developed from imported infection. However, it must be realized that quarantine protection at frontiers, ports, and airports does not provide complete protection from the risks of such importation. Behind their frontier defences, the countries must be made resistant to these diseases, should they be introduced. Thus, the danger of cholera will be eliminated by protection of water supplies and sewage disposal; of typhus and relapsing fever by personal hygiene which will prevent body louse infestation; of smallpox by systematic vaccination; while plague will be largely eliminated by the ratproofing of ships, warehouses, and food stores.

Thus does the development of public hygiene and sanitation allow the suppression of strict quarantine controls which remain indispensable to the hygienically less developed countries.

Theoretically, therefore, international quarantine could be regarded as a temporary tool, to be dispensed with when all countries are developed hygienically and unreceptive to pestilential disease. But although considerable progress is being made, this ideal is still far distant, and other methods are being applied for the international control of these diseases.

If, to combat yellow fever and plague, the best means of preventing international spread are still to make the ports and airports *Aëdes* free and ratproof, to disinsectize aircraft and to deratize ships; to combat smallpox and cholera, it seems possible to take an even more positive attitude. A campaign of world-wide eradication of smallpox was launched in 1955 under the sponsorship of WHO and is now under way. As to cholera, its endemic haunts are being delineated and methods are being tested to control water supplies at costs which would not be prohibitive.

It may well be that such attempts to carry active warfare into enemy territory may prove more effective, and in the long run cheaper, than to keep the purely passive attitude of maintaining quarantine barriers around every country.

World Health Goals in Environmental Sanitation*

Herman G. Baity, Sc.D.

TO PRESENT THE FORWARD LOOK of environmental sanitation in a world-wide framework is a task which would challenge the combined abilities of a statistician, a dramatist, and a prophet. I wish it were possible to bring home to you a realization of the burden of sickness and death from environmental causes that prevails among the massed populations of most of the world; to you in this country where a single case of typhoid fever is a signal for mobilizing the combined resources of a health department, and where a single case of cholera would produce panic.

I might describe to you individual pictures, such as that of a father carrying in his arms a pitiful bundle containing his dead child, striding with stony face along the road leading to the sacred river, to confide to it all that remains of his love, his expectations, and his hopes for his son; or I could describe the callousness and indifference, born from long habituation to their duty, with which men collect each morning the bodies of those homeless dwellers of the streets who have died during the night just past.

On a larger scale, perhaps I could attempt to give you an account of the needless losses to a nation from death and from illness in its productive population, losses which are staggering to countries where economic resources are already woefully inadequate by any standards you can conceive. In a single country, for example, in the 1940-1950 decade, 27½ million of its people died of diseases transmitted by water and food, and in the same period almost 20 million were victims of malaria. If laid head to foot, these pathetic corpses would reach twice around the world at the equator. This is an appalling sacrifice of life from preventable disease, and in a country where the life expectancy at birth is only 28 years. In such situations, the economic burden due to morbidity is even greater than that due to death.

Even more difficult to delineate is the course by which such tragic environmental conditions may be improved, in the face of ignorance, poverty, and the habits and traditions of the ages. How to get even the first toe hold in the long climb from this abyss is exceedingly difficult. The World Health Organization with the earth as its field has a constitutional responsibility, and an opportunity, to do something to improve this situation. The Organization has itself become convinced that sanitation is problem number one with most of the world's population, and has turned its attention and resources to the attack.

Sanitation throughout the world is closely related to the general level of development in each area. In the least-developed areas (those countries which may be described as in the lag phase of development), sanitation is very poor, or non-existent. Poverty is an almost universal condition, and funds or other material resources are virtually unavailable. Trained and skilled public health workers simply do not exist at the local or operating level. Ignorance and apathy are the principal forces to be overcome. In other areas, one may find a surging tide of growth in all fields of economic and social interest, and here sanitation programs can begin to create substantial improvements.

There are many reasons why sanitation programs have been slow in developing. Frequently there is no real recognition of the meaning, the history, and the potential of sanitation. The term is used sometimes to refer only to excreta disposal. One country has put such a limited interpretation on the word that the government has established a "National Water Supply and Sanitation Program." Such a limited use of the term clearly reveals a lack of understanding of the potentiality and the basic interrelated elements of a sanitation program. Frequently, also, the sheer enormity of the task is so overwhelming that a sense of despair prevents any action being started.

*Presented before the Forum Session of "World Health Goals" at the third annual meeting of the National Citizens Committee For The World Health Organization, November 16, 1955, in Kansas City, Mo.

Dr. Baity is Director, Division of Environmental Sanitation, World Health Organization, Geneva, Switzerland.

Another deterrent arises from an expectation that is held in many quarters, not excepting some in the United States, that if action is delayed at local levels, sooner or later a higher level of state or central government will accept responsibility, and in some magical way the work at hand may be done without cost to the community.

In the parts of the world where work in rural sanitation has been undertaken, the observer is often more impressed by the pathetic debris of unsuccessful projects than by the positive results of successful undertakings. He wonders why there is often such dismal failure in an effort that appears to him to be so simple, so promising, and so much to be desired by its beneficiaries. It is not only an instructive exercise, but also it is an urgent necessity, to examine the reasons for such failures, so that future planning can be based on a realistic analysis.

Some of these unsuccessful efforts are found to be isolated projects instead of part of a general environmental sanitation program. There was no plan into which the project fitted logically as to time and place. In others, there was no real integration of sanitation into the general health services of the country. Not infrequently, projects have been started in countries where there was no environmental sanitation unit in the health organization staffed with personnel competent to plan, promote, administer, supervise, and follow up the project activities. In other instances, in spite of lip service to the virtues of health education, there has been inadequate attention to the education of the public who were expected to use the improved facilities, or to the enlistment of their active participation in construction and maintenance. Often projects have been started on such a scale that there was a dearth of personnel qualified to carry out the various functions associated with the projects. Sometimes there has been great enthusiasm for a campaign-type of activity, with little attention to an adequate definition of responsibility for the maintenance of the project or for the encouragement of its full use. A critical cause of failure has been the absence of a fiscal plan for the upkeep of the project and its extension into a broader program in the country.

Under the stimulation and guidance of WHO and other international and bilateral agencies, the member countries of the Organization are showing an upsurge of interest in the improvement of sanitation. This is particularly noticeable in Southeast Asia and in Latin America.

The Government of Ceylon has already embarked on a program for the betterment of rural sanitation. A pilot project is under way there to show how the present system of dipping water from irrigation ponds and shallow pits can be replaced by the use of safe wells and springs, and how indiscriminate defecation can be stopped by the construction and use of proper latrines. This pilot project includes the necessary support of health education, laboratory services, and statistical evaluation. The project is being made a training centre, and from it will come the people who, it is hoped, will expand similar programs throughout the country over a period of some five years.

Plague in India. Villagers lend a hand with the baiting of traps for house rats.

India, largely through the stimulation and financial support of the American FOA (now ICA), has inaugurated a mammoth rural sanitation program involving some 30,000 villages. This plan has one particularly desirable feature by which government grants, in their successive allocation to states and local areas, are progressively multiplied by contributions at each level, in an effort to meet the costs of this program in an equitable way. Incidentally, this Indian program affords an excellent example of interagency co-operation, where several organizations are working together amicably toward a common objective.

Burma has undertaken a national program for the improvement of rural water supply, and has set up an effective organization to carry out this important work.

In Latin America, spurred by the successes of programs in several areas, country after country is seeking aid from WHO in the establishment of national projects. The effective work of such agencies as the Institute of Inter-American Affairs over the past several years has already contributed largely to the development of country programs, and the

demand for expanded services is growing. To illustrate the growth of this demand, WHO, through its regional office and the Pan American Sanitary Bureau, has been asked to supply engineers within the next few months for work in Nicaragua, Venezuela, Colombia, Mexico, and Uruguay.

Not all of the sanitary progress is taking place in the less well-developed sections of the world. In Europe last summer, a conference on sanitary engineering education took place at Oxford University, an indication of the awakening desire of European countries to develop stronger sanitation services in their national health organizations. The Netherlands have now appointed a sanitary engineer at the ministry level.

To support this growing interest, WHO has embarked on a program of providing useful and authoritative information relating to sanitation. A manual on the composting of refuse has been completed and is being printed at the present time. Two other manuals on rural water supply and rural excreta disposal are in preparation. On a somewhat different level, WHO has undertaken the study of existing practice and the drafting of an international standard of drinking water quality, together with standard methods of water analysis, which can be recommended to all governments for their acceptance and use. Another manual, of great interest to the aviation industry and to international travellers, will deal with the hygiene and sanitation of international airports.

Progress in health improvement in the underdeveloped areas is necessarily slow. This is particularly true of sanitation in the rural regions, where its significance must be learned, habits changed, and facilities built and used. No very great changes may be expected in less than a generation, because they must depend primarily upon the rising generation. But to look ahead for a period of, say, five years, it is not too much to expect of governments that they set the stage for the coming drama by doing at least the following basic things:

1. Recognize the real benefits of sanitation to the health and well-being of their people.
2. Establish a sanitation unit within the national health service of the country, commensurate with the country's needs and resources, and staff it with personnel competent to plan and direct all phases of work in this field.
3. Integrate sanitation properly with other public health undertakings, and see that first things come first.
4. Develop a long-range plan of sanitation for the country as a whole, into which projects and programs may logically be fitted as to time and place.
5. Realize that it is possible to do something helpful in environmental sanitation under any conditions and under any budget, and that the simplest things are usually most important.
6. Select a point of beginning, always the most difficult step in such an undertaking, and outline an orderly progression of work and objectives.

The interest of WHO in the field of sanitation has been affirmed time and again by its governing bodies. But WHO is not the doing type of agency. Its functions are essentially stimulative, advisory, and demonstrational. It has a small budget and employs relatively few people. WHO cannot by itself make much impression upon the world-wide task in sanitation that needs so desperately to be done. It depends upon the united support and cooperation of its member states, other international agencies, and individuals from every walk of life. It is not a supranational health agency, clothed with unique authority and power. It is instead an association of states, organized for co-operative effort, and as such it provides an unparalleled opportunity for bringing knowledge, skill, experience, and means from the more highly-developed parts of the world to bear upon the forces of ignorance, apathy, poverty, and despair which have so long imposed a cruel burden upon less fortunate areas.

Venereal Disease Control Programme in India

R. B. Tampi, M.B.B.S.

THE CONCEPT of the venereal disease control program in India in its present form is of recent origin. Even though clinic and treatment facilities have been in existence in the larger cities and teaching institutions, there were few or no facilities for a broader control programme, including epidemiological work, and for the treatment of larger groups of population in the rural parts, in some of which disease was prevalent.

A preliminary survey, carried out in April 1949, discovered an area of high incidence of syphilis in Himachal Pradesh in North India. Treatment and diagnostic facilities were inadequate. Facilities for both undergraduate and postgraduate training in this specialty were limited. Even where such facilities existed, the bias was toward the clinical aspect. The practicability of mass campaigns against the venereal diseases and of reducing their incidence by using antibiotics and the simpler serologic techniques was demonstrated in other parts of the world.

It was in this context that the WHO in collaboration with the Government of India and the Government of Himachal Pradesh established in May 1949 a VD demonstration team with headquarters at Simla. The main objectives included the establishment of a VD diagnostic laboratory, demonstration of the efficacy of antibiotics in the treatment of venereal diseases in an economic and ambulatory manner consistent with the resources of the country, evolution of a standard technique for the field operations in VD campaigns, and training of medical and auxiliary personnel from the different states in India and other areas in this specialty.

The team consisted of international staff and a matching team staff. All the necessary clinical, laboratory, and health educational equipment and PAM (procaine penicillin G in oil with aluminum monostearate) were supplied by the WHO. The VD laboratory and main clinic were established in Simla. In 1950, a subsidiary unit was also set up in Nahan, the headquarters of one of the districts in Himachal Pradesh. The Simla clinic and laboratory were used as the base for subsequent field surveys and mass treatment programmes in the interior parts. The team also carried out certain sampling serologic surveys in areas outside Himachal Pradesh. In Himachal Pradesh, the seropositivity detected varied from 10 to 50 percent. One of the areas with a high incidence of seropositivity and clinical syphilis was chosen in November 1949 for a mass treatment demonstration. Concurrently with mass surveys, the team also gave treatment with PAM to the infected cases.

In December 1951, the WHO VD Demonstration Team was withdrawn, leaving the work to the VD Organization Himachal Pradesh to continue. Two more sub-units were formed and set up in the two other districts of Himachal Pradesh with the aid of UNICEF field equipment. By the end of 1952, all the staff for the sub-units were trained and posted. Four full units were thus functioning from 1952, doing both clinic and field work.

The consolidated available figures of the total number of new cases tested in Himachal Pradesh during the different years is given below:

1949	8,294
1950	16,844
1951	11,278
1952	21,608
1953	46,231

Syphilis was the most common of the venereal diseases present. The following represent the proportion of the more important venereal diseases seen in the clinics in Himachal Pradesh:

Disease	Percent
Syphilis	90.00
Gonorrhea	8.00
Granuloma inguinale	1.25
Lymphogranuloma venereum and chancroid	0.75.

In 1949, the effect of streptomycin in the treatment of granuloma inguinale was demonstrated by the team for the first time in the area. As the work

Dr. Tampi is Venereologist, Safdarjang Hospital, New Delhi, and Adviser on VD to the Government of India.

progressed, the problem arose of overcoming certain superstitions and misgivings of the people regarding bloodtaking. The initial hostile attitude gradually changed and now people come forward more freely for tests and treatment.

Training of the teams for the different states was an integral part of the programme of the WHO VD Demonstration Centre. From December 1949 to September 1951, training was given to 60 persons in various aspects of the work. The course was for three months for all categories of personnel and included field training. Each team consisted of a clinician, serologist or technician, and a nurse or social worker. UNICEF agreed to supply each trained team with a set of serologic equipment, antigens, and PAM for the treatment of women and children, subject to certain "matching" commitments being fulfilled by the state governments. To date, 18 such centres have been equipped.

In 1953, about 100,000 new cases of syphilis were treated by these WHO/UNICEF assisted VD centres in India. The cumulative effect of the measures employed is seen in the reduction of the reservoir of infection in the areas of high incidence. This was particularly demonstrated in the Ghund area in Himachal Pradesh.*

In November 1949, the original treatment with PAM was given to all available individuals. Prior to that, about 12 patients with syphilis used to report for treatment in the local dispensary every month. The area has been under close and periodic supervision and, by 1953, it was noted that hardly a single new case was coming, apart from those rare instances imported from adjoining areas. There has also been a marked lowering of the sero-positivity rate and lessening in the quantitative titres of those previously treated. Another effect noted was that numbers of families who had had no children before had begun to have them.

In Himachal Pradesh, the treatment and testing are free to all patients and the whole structure of VD control measures has been integrated into the existing health services. The bloodtaking facilities have also been gradually extended to all the outlying hospitals and dispensaries, and a scheme has been evolved to mail specimens in merthiolated tubes to the nearest VD laboratory. Case-finding measures were also expanded by routine serologic tests on all hospital admissions, antenatal patients, and selected outpatients in the bigger headquarters hospitals. During field operations, the aim was for quick and wide coverage of the population in the area. Wherever possible, revisiting of the areas was arranged.

Health education and contact tracing work were also developed by the team in Simla. It was the experience of the team that the maximum benefits from VD programmes could be obtained by a concurrent improvement in the environmental hygiene and social habits of the people. In the hilly parts, some of the social habits are particularly conducive to spread of venereal diseases.

The role of the laboratory diagnosis of venereal diseases was particularly stressed in all the programmes. The Meinicke and VDRL tests were found simpler and easier to perform than others, and particularly suitable for routine work and in field operations. The UNICEF equipment given to the teams was designed to allow the performance of these tests. The importance and urgent need for standardization of the testing procedures in this country was discussed at a serologic conference arranged by the Regional Office of the WHO in November 1951. During the same conference, the necessity for a uniform policy in the training of laboratory personnel, particularly laboratory technicians, was also discussed.

In order to meet future requirements of essential items for VD control work, the Government of India with the assistance of the United Nations Technical Assistance Fund has started a penicillin production unit and cardiolipin antigen unit. This will go a long way to help the expansion of VD control projects in India.

The foundation and methodology for a VD control programme in India are now set. With the generous assistance and guidance of the WHO/UNICEF and the medical and non-medical services of the country, it is a suitable opportunity to utilize the experience so far gained and implement a positive program on a wide scale. With the present knowledge and application of modern principles, it should be possible to reduce the incidence of venereal diseases in this country.

WHO/UNICEF are also helping this country in fighting allied diseases, as in the yaws control programme. These programmes are at present in operation in the states of Madhya Pradesh and Hyderabad. Activities in Andhra State are expected to commence shortly.

A WHO team consisting of a serologist, a public health nurse, and a medical social worker (provided by UNTAA) was working with the upgraded VD Department, Government General Hospital, Madras, from mid-1952 to the end of 1953. WHO has further provided equipment and supplies to this centre, and training facilities in the

*Bull. Wld Hlth Org. 5: 377-439, 1952, and Bull. Wld Hlth Org. 7: 83-101, 1952.

Fig. 1. An Indian woman doctor working with the WHO VD control team takes a blood sample from a woman patient. All the samples are subsequently tested in the team's laboratory and records are kept of each patient's progress. Fig. 2. The team leader explains how one single injection, given by the team three months before, has healed this farmer's shoulder blade. For years previously, the whole shoulder had been covered with a running sore caused by syphilis. He has now had a second penicillin injection.

various aspects of VD control are now available at Madras.

A yaws control programme in Coimbatore district, Madras, and a mass VD control programme in Jammu, with possible WHO/UNICEF assistance, are under the active consideration of the state governments concerned.

In conclusion, the following by Bauer* is quoted:

"Towering above all other results, real or potential, of international treponemal and venereal disease control is the prospect that the massive prevalence of these diseases may be cut down and possibly eradicated in large areas. Both in the terms of humanitarian objectives and of economic improvement of the areas involved, this prospect has very broad ramifications indeed.

"It has been pointed out that treatment alone has never eradicated a disease on a global scale; neither has vaccination nor environmental sanitation. But history abounds with instances of disease controlled by public health methods, and WHO's experience with mass treatment of venereal and treponemal disease encourages the belief that control and possibly eradication of these infections can be achieved."

*Bauer, T. J., Half century of international control of venereal diseases, Pub. Health Rep. 68: 779-787, Aug. '53.

Some Aspects of International Health Work

M. G. Candau, M.D., M.P.H.

On July 22, 1946, just ten years ago, the Constitution of the World Health Organization was signed by the representatives of 61 countries attending an international health conference which had been called in New York for that purpose. The great majority of these signatures however were subject to ratification by the governments concerned, and the conference agreed that an interim commission should be set up to carry on the more pressing of the functions of an international health organization until the constitution came into effect. It was not until April 7, 1948, that the required number of ratifications (from 26 member states of the United Nations) were secured. It will not be until 1958, therefore, that the Organization officially celebrates its tenth anniversary.

Ten years have nevertheless passed since the decision was taken to set up WHO, and the time may be opportune to look briefly at some of the achievements that the Organization has to its credit, and to review some of the changes and shifts in emphasis that have resulted from the inevitable trial and error period of its early years.

There is one important area of international health work in which WHO has been able to profit from the experience of earlier health organizations. This includes many world-wide health services which benefit all countries alike, and also, ultimately, industry, trade, and communications.

For seventy years after the first international sanitary conference met in Paris in 1851, quarantine measures were the one and only health matter dealt with internationally. It was not until a century later, in 1952, that comprehensive sanitary regulations, agreed to by the great majority of WHO member states, brought a reasonable measure of order into what had been a chaotic situation, and opened up a prospect of protecting all countries against the introduction of pestilential disease, while at the same time ensuring the widest possible freedom to travellers, and the least possible delay in international freight transport.

Dr. Candau is Director-General of the World Health Organization.

Other fields in which WHO has carried on work begun by earlier international organizations are the analyses of vital and health statistics from all countries, the establishment of international standards for drugs and biologicals, the publishing and keeping up-to-date of the "Pharmacopoea Internationalis," and the "International Statistical Classification of Diseases, Injuries and Causes of Death." Then there are also the various types of scientific and technical publications of WHO, devoted to reviews of subjects of importance to international health and medicine. Readers may possibly be familiar with some of them, such as the "Bulletin of the World Health Organization," "The International Digest of Health Legislation," "The Weekly Epidemiological Record," "The Monthly Epidemiological and Vital Statistics Reports," as well as the WHO monographs on specific health topics.

All these are, as it were, the traditional duties of an international health organization, and in most of them WHO has simply made some advance on work already initiated by the Paris Office international d'Hygiène publique, the Health Organization of the League of Nations, and the U.N. Relief and Rehabilitation Administration.

Work of a much more pioneer character has been that of WHO's advisory services to individual countries. Faced by a multitude of urgent health problems, some of them practically world-wide and some confined to certain regions only, the Organization was obliged to begin with the most obvious need of most of its member countries—the fight against widespread and economically-important diseases such as malaria, the trepanematoses, and tuberculosis. But it quickly became apparent that the control of individual diseases, important though it was both for the country concerned and for the Organization which thus quickly gained in standing because of the spectacular nature of some of the

results achieved, was a very small contribution indeed towards the objective which WHO had set itself: "The attainment by all peoples of the highest possible level of health." More and more in recent years, WHO programmes of direct assistance to its member countries have therefore been aimed at strengthening their own national health services. Whether they are centralized at headquarters or carried out through the six regional offices, most of the co-ordinating and leadership functions of WHO are directed towards this all-important objective. This is reflected in the growing development of inter-country education and training programmes for medical and other health personnel, and efforts generally to extend the exchange of medical and scientific information among member countries. The widening scope of activities sustained by the Organization to help countries to cope with the acute shortage of adequately trained health personnel can be measured by the fact that, in the last two years, more than 40 percent of our projects in all regions were mainly concerned with education and training. In addition to providing assistance in the establishment or improvement of medical schools, nursing schools, and other training and research institutions, WHO experts and consultants are reviewing their curricula and, what is even more important, their effectiveness in relation to local health needs. Indeed, it should by no means be assumed that methods of education already established in a given area, are automatically suited to other areas where public health problems may be entirely different. In areas where 85 percent of the population is undernourished, where villagers are badly housed, and elementary sanitation is lacking, the general practitioner of medicine will need other qualifications than, for instance, familiarity with the latest techniques in x-ray diagnosis, electroencephalography, electrocardiology, and so forth.

However, it remains generally true that, subject to the necessary modifications and adaptations, experience gained in one area can be usefully applied in others. Seminars, conferences, study groups, and study tours arranged on a regional or inter-regional basis are therefore considered to be increasingly useful as vehicles for the exchange of scientific information and experience, in addition to providing inspiration and stimulus to their participants for the promotion of health improvement.

The reader may be interested to learn about some of the conferences held in 1955 to promote medical education. In New Delhi, 132 medical education experts gathered to examine the type of training needed to resolve India's shortage of medical manpower. A conference held in Chile, and attended by deans and professors from 40 medical schools in South America, discussed the teaching of preventive and social medicine. The same subject was also investigated by a group of medical educators from six countries who visited Egypt.

One example will illustrate the value of international training courses. The anaesthesiology training centre in Copenhagen has been in existence for five years, and we now have some indication of the results obtained. The effect on Denmark was to accelerate the development of anaesthesiology as a separate discipline. There are now five anaesthesiology departments in Copenhagen hospitals, and about 20 chief anaesthetists in the country as a whole. During the last five years, the centre has trained 127 anaesthetists from 24 countries in Europe and the Eastern Mediterranean Region.

The awarding of fellowships is one of the most important ways in which WHO tries to improve medical education and training. Since the creation of the Organization, more than 5,000 fellowships have been awarded to physicians, nurses, sanitarians, and other health workers. The truly international character of this programme is revealed by the fact that during a one year period, 1,100 Fellows were received by 577 institutions in 42 countries.

In discharging its new responsibilities in the field of nuclear energy, the Organization will greatly benefit from methods and techniques already evolved in other fields, during the last few years, for the training of personnel, the dissemination of scientific information, and the stimulation and coordination of research. All this experience will be carefully applied to the two main types of activity WHO is to carry out with regard to the development of nuclear energy: the first relating to the use of radioisotopes in medical research, and in the diagnosis and treatment of disease; the second aimed at protection against the risks of radiation. In 1955, the Eighth World Health Assembly assigned priority to the latter, and there is a particularly urgent need for public health personnel to acquire scientific knowledge of all the implications of the use of nuclear energy. In addition, there will be an increasing demand for trained personnel in the field of protection in atomic plants, research institutions, and hospitals using radiation techniques.

It is essential to realize that, with the increased use of nuclear energy, protection against radiation becomes a serious public health problem. Man has, of course, always been exposed to natural radiations but, as time goes on, the ambient radiation

Boy in village of Farimaneh, Iran, is dusted with BHC insecticide. All the 400 villagers, together with their clothing and bedding, receive this treatment regularly to destroy typhus-carrying lice.

level will be considerably raised by artificial sources, unless these are controlled. It is possible that this intensification of background radioactivity will have some somatic and genetic effects on mankind as soon as a large proportion of the world population is exposed to it. For the time being, the danger is still very small; but if we are to cope with it before it becomes significant, we need better quantitative data on the effects of radiation on mankind. Since it will obviously take a long time before firm conclusions can be reached and implemented, it is necessary to envisage at once a world-wide study of both somatic and genetic effects. Here WHO will play its customary role by stimulating research, co-ordinating national programmes, and helping in the standardization of methods and techniques, in order to make the results obtained comparable at the international level.

At the International Conference on the Peaceful Uses of Atomic Energy, which took place in 1955 in Geneva, a number of scientists from various countries emphasized the need for co-ordination by an international organization.

In the all-important field of training, a first step was taken by WHO by sponsoring an international training course on protection against radiation, organized by the Swedish government in co-operation with the U. S. Atomic Energy Commission. A series of lectures and demonstration courses was given by nuclear scientists from the United States, Sweden, the United Kingdom, and France. They were attended by physicists and physicians from ten countries, specialists in radiation work, who were anxious to obtain further knowledge on health problems arising from the ever more complicated apparatus used in nuclear physics.

In the field of communicable diseases, one important problem WHO is facing is the possible development of resistance of several disease carriers to insecticides. The Organization is at present stimulating and assisting research work to ascertain whether the routine use of insecticides in louse control may not lead to an increasing degree of resistance. Should this be the case, urgent action will be necessary to achieve control of typhus before resistance by lice impairs the efficiency of insecticides. Similarly, the study which is now being undertaken on the possible development of resistance in *Aëdes aegypti* mosquitoes will determine future control operations carried out against yellow fever.

While in the case of typhus and yellow fever it is fortunately still not certain whether the vectors will acquire a significant degree of resistance to insecticides, the capacity of various malaria carrying anopheline species of mosquito to acquire resistance, after some years of exposure to insecticides, at least in some areas, seems to be an established fact. There is also the expectation that, in the future, new substances will be discovered which will kill insects which have acquired resistance to chlorinated hydrocarbon insecticides. At the present stage of knowledge, however, resistance constitutes a problem for which the only solution is to aim at the eradication of malaria in the shortest possible time, whenever this is technically feasible. In view of this situation, the Eighth World Health Assembly, held last year in Mexico, adopted a resolution which "requests governments to intensify their plans of nation-wide malaria control so that malaria eradication may be achieved and the regular insecticide spraying campaigns safely terminated before the development of resistance to insecticides in anopheline vector species materialises."

As a consequence of the fact that the achievement of malaria eradication appears quite possible in most of the malarious regions of the world (with reservations, however, as regards tropical Africa), new duties are being laid upon governments as well as upon WHO. It is clear that no single international organization can do more than stimulate and support government action in this vast endeavour. Governments must then provide the means, knowing that, if eradication is achieved after a few years, malaria control expenses will then be reduced to a low maintenance level amounting to only a fraction of what active control costs now. For its part, the Organization shall, according to the resolution of the Assembly, "take the initiative, provide technical advice, and encourage research and co-ordina-

tion of resources in the implementation of a programme having as its ultimate objective the world-wide eradication of malaria." For this purpose, special credits were earmarked from the regular budgets for 1955 and 1956; and, moreover, the establishment of a special account, to be credited with voluntary contributions, either in currency or in kind, whether in the form of services or supplies and equipment, was authorized by the Assembly. Furthermore, UNICEF, which gives material help to many disease control programmes, now seems decided to give more generous aid to those aiming at malaria eradication.

The example of malaria shows that, even in regard to what we may call the old, traditional disease problems, it is the duty of WHO to keep pace with current scientific developments and progressively to modify its approach to specific diseases in the light of both new discoveries and the changes which may occur in epidemiological conditions. In our struggle to achieve world-wide health and prosperity, there is no room for complacency. We must be constantly on the alert and ready to attack any new problem which arises.

Now I should like to turn for a moment to a problem which has been very much in the headlines lately, poliomyelitis. There is evidence that this infection has been present in the world for thousands of years; yet, until 50 or 60 years ago, it was regarded as a medical curiosity. Then, in the early years of this century, there were some disturbing epidemics, mainly in Scandinavia and North America, but the average incidence over the years did not increase alarmingly and in most parts of the world the disease remained rare. During the past twenty years, all this has changed; epidemics have become both more frequent, and more serious, and have affected countries and peoples previously spared. And, instead of affecting infants only, the disease has begun progressively to affect children, adolescents, and adults, in whom it tended to be more severe. We now know that the virus is widely spread throughout the world but that, for various reasons, the probability of the occurrence of epidemics and the average age of the patients both tend to increase, as countries improve their social and hygiene practices and their living conditions.

Poliomyelitis is therefore now, actually or potentially, a world problem. In many areas, it is not yet a serious problem; but we must, if possible, prevent it from becoming one.

In another field, development in the chemotherapy of tuberculosis was reflected in a change of emphasis in WHO's approach to this disease in 1955. While the Organization continued to assist BCG mass vaccination campaigns as well as teaching and training centres in a number of countries, it was confronted with new tasks as a result of recent trends in dealing with tuberculosis. More and more countries are turning to WHO for information and advice on the use of ambulatory treatment as a control measure. In addition, the need for more accurate information on the prevalence of tuberculosis is being more generally recognized.

The Government of the Philippines has launched a nation-wide campaign against tuberculosis. Nurse inside van presented by UNICEF prepares boy for roentgen ray examination.

The Organization is thus concentrating much of its effort on developing satisfactory techniques for surveys of tuberculosis; on helping governments to carry out such investigations; and on studying how simple, economical control measures can be fitted into the existing public health programmes.

During 1955, assessment and survey teams were working in the Eastern Mediterranean, Southeast Asia, Western Pacific, and African Regions; and, at the same time, preparations were made for joint studies of the effects of domiciliary treatment with anti-tuberculosis drugs, to be undertaken in 1956 in conjunction with the Indian Council of Medical Research and with the assistance of the British Medical Research Council.

To turn to yet another problem, the theme "changes in health services necessitated by the ageing of populations," which was chosen as the subject of technical discussion for the 1955 session of

the European Regional Committee, is typical of the kind of question with which WHO is increasingly concerned in the highly industrialized countries. The discussions covered the need for skillful and special measures of rehabilitation of the aged; the therapeutic value of selected, paid employment for old people; and the role that central administrations can play in promoting research into, and studies of, various features of the ageing process. The fact that in Germany, for example, the number of people over 65 years has now reached 10 percent of the whole, shows that these problems affect an important proportion of the population.

Another group of diseases which have assumed a dominant role as causes of morbidity and mortality in many countries of Europe and America include cancer, cardiovascular diseases, diabetes, and rheumatism. The study group convened by WHO in 1955 to examine atherosclerosis, and particularly its association with ischemic heart diseases, is a first manifestation of the Organization's concern with this type of illness. As to cancer, WHO's work in the future will be guided by the advice it receives from a consultant group on the ways in which the Organization can effectively assist and complement the vast national efforts being carried out in this field.

However, the most serious health problem in economically well-developed countries remains mental health. The preventive and therapeutic psychiatry of children continued to be the main object of WHO's mental health programme. The third session of the Study Group on the Psycho-Biological Development of the Child was held in Geneva in February, and arrangements were made for the proceedings of the first two sessions to be published by a commercial firm.

Another study group, which met in London in October, discussed the various aspects of juvenile epilepsy and considered the establishment of community programmes for epileptic children.

Finally, as a follow-up to the seminar which met in Amsterdam in 1953, a study group was convened in 1955 to examine mental health problems in different countries, and the practical difficulties of applying principles of mental hygiene to public health services. One of the conclusions reached by the study group was that mental hygiene work in public health should not be considered as a specialized job and that, therefore, the key to the situation lies in the training of the future physician, and of all members of the public health services, including nurses and social workers in mental health.

In the preceding pages, I have attempted to give some examples of the potentialities, problems, and also limitations of the Organization in achieving the long-term objectives it has set for itself. Eight years are but a short moment in the life of an Organization with such a wide objective, but there is already unmistakable evidence that the work carried out by WHO since its creation is yielding important results. Throughout the five continents, experts and teams of WHO are today assisting national health authorities to develop and perfect their means of controlling disease and of ensuring better health. Thanks to a great number of health projects undertaken, individually or collectively, by the countries which have joined WHO, there is fresh hope today for the great majority of the population of the world, whose strength to live and capacity to work are still undermined by ill-health. And, above all, for the first time in history, a world-wide organization is today endowed with powers of direction and co-ordination in health matters and can thus see to it that internationally available means are used in the most economical and most effective way.

I am convinced that with the increasing co-operation of all Member States, the World Health Organization will continue to discharge the functions assigned to it by its constitution and will thus be able to play its full role in the building of a healthy and prosperous world community.

Leprosy in the Western Pacific Region

Lawrence O. Roberts, M.D., M.R.C.P., M.P.H.

LEPROSY IS FOUND in all the countries of the Western Pacific Region, from Japan and Korea in the extreme north to the Maoris of New Zealand in the extreme south; from Singapore in the west, eastward to the islands of the mid-Pacific. It is not, of course, an equal problem throughout, for it most prevalent in the less-developed areas where there is a low standard of living and a minimum of popular education and social enlightenment.

The countries where leproy is most prevalent are, all too often, the very countries where accurate statistics are most difficult to obtain. In Vietnam, Cambodia, and Laos, in Sarawak and North Borneo and in the two halves of New Guinea, for instance, it is known that leprosy is a problem of sufficient magnitude to merit attention, but how big the problem is is not certainly known.

In the Table, however, are shown some figures which are of sufficient accuracy to be worth discussion, and they demonstrate two principles of general importance: as one moves from the temperate through the tropical to the equatorial zone, the prevalence of leprosy rises markedly and the percentage of lepromatous cases falls. This is in line with observations made in Africa indicating that darker skinned races are more liable to contract leprosy and also to contract the tuberculoid form. In the Western Pacific Region, it is only in the equatorial zone that one finds high prevalence rates. Even in Korea, a country suffering severely from the after-effects of war, the prevalence (based on government estimates) is only 2 per thousand; considerably higher than Japan, it is true, but considerably less than the Solomon Islands. In Australia, the disease is endemic among the black-skinned aborigines in the northern part of the continent; in New Zealand, a few cases were reported annually among the brown-skinned Maoris. It is practically unknown among the white population.

Surveys. Strictly speaking, only a properly conducted survey can reveal the true prevalence, and only repeated surveys can show the true incidence and the trend, upwards or downwards, of the prevalence. Intensive surveys† have been conducted in the Philippines by the Leonard Wood Memorial and have given information unmatched anywhere in the world; and extensive surveys † have been carried out in a number of places, notably in certain Pacific islands, where a relatively small and circumscribed population renders the work not too difficult and expensive. Although leprosy surveys still have their place, it seems likely that they will

Dr. Roberts is Regional Tuberculosis Advisor, WHO Regional Office for the Western Pacific, Manila, Philippines.

TABLE

Country	CASES Known	Estimated Total*	Estimated Cases per 1,000 Population*	Percent Lepromatous
Japan	11,206	15,000	0.17	62
Philippines	10,673	20,000	0.95	42**
Solomon Islands	1,000	2,000	20.00	20 (approx.)

*Where estimates differ, the latest official (government) one has been used.

**Percentage found in intensive field surveys. Of all those registered, 34.2 percent are lepromatous.

†An intensive survey is one where 100 percent, or almost 100 percent, of the population are examined in a small geographic area. An extensive survey is one where only sample groups, believed to be more or less representative of the whole population, are examined in a larger geographic area.

be less essential than formerly. Modern mass chemotherapy has opened a vista of treatment campaigns, automatically combined with extensive surveys, and based on the mobile worker and the domiciliary patient. And such campaigns make it appear that the purely epidemiological survey may be an unnecessary expense in the future.

As regards upward or downward trends, it is known for certain that the incidence is declining in certain parts of the Philippines; it is believed to be declining in some other areas (Japan, Singapore) and to be worse now than 20 years ago in others (the Solomon Islands). In this region, Muir's dictum: "The two main signs that leprosy is diminishing in an area are a high lepromatous rate and a low child rate" has not proved very reliable. In a considerable number of countries and territories, any estimate of the trend can be no more than a guess.

Before the sulphone era, leprosy control was based on segregation, often compulsory, mostly in leprosaria. Some of these were small, containing perhaps only a dozen patients, while others were very large; Culion, for instance, cared for 7,000 persons. Among the best known were Makogai in Fiji, the Leonard Wood Memorial in the Philippines, and Sungei Buloh in Malaya. Specific treatment was relatively ineffective and the leprosaria accomplished little more than isolating a fraction of the total number of cases, carrying out an important volume of research work, and causing widespread concealment of the disease through fear of compulsory segregation.

After World War II was over, the inflated cost of goods and services forced governments to recognize certain facts which formerly had been mostly glossed over. First, the cost of leprosaria was out of all proportion to their value in a total control programme; and second, because they could deal only with a small proportion of the total patients and because they too often led to concealment of disease among the remainder, they were unlikely to make a significant reduction in the leprosy problem as a whole. In Korea at one period, no less than one third of the total health budget was spent on the upkeep of leprosaria and in the Philippines a formidable sum was needed annually.

It was indeed fortunate that medical research at this point placed in our hands a specific remedy which could, in many cases, render infectious cases noninfectious and which could be administered on a large scale to outpatients.

Sulphones are being used in institutions and dispensaries throughout the Region, in the usual doses and with the usual adjuvant drugs, such as ferrous sulphate, and with much the same results as have been reported from other parts of the world. For the first time, a specific remedy for leprosy is available; for the first time, the patients can see themselves and each other getting better; and for the first time, they are coming forward, voluntarily and in large numbers, for treatment.

It was to take advantage of this development that WHO and UNICEF decided to assist governments to set up case-finding and mass treatment programmes on a domiciliary basis. In the Philippines, for example, a pilot project was initiated in 1955 by the government with WHO/UNICEF assistance. Two special teams were recruited, trained, and dispatched with vehicles to the provinces where prevalence was believed to be high. They are now making an extensive (not intensive) sweep through these areas, examining school children, contacts of known cases, and persons voluntarily attending the sessions of the mobile skin clinics; they are diagnosing leprosy, starting treatment (DDS by mouth and ferrous sulphate when appropriate), and handing the treatment over to the rural health units when they move on to another case-finding area. The emphasis is on home treatment, not isolation, and skin diseases other than leprosy are treated to encourage larger numbers of people to come forward for examination. Although it is too soon to speak of results, it can be said that the teams are finding more cases than was expected, and as excellent initial results from regular sulphone treatment have been noted as were found in similar campaigns carried out in other parts of the world.

Brief mention must be made of leprosy campaigns in certain other countries. In Singapore, the registration of cases is at, or close to, the 100 percent mark; there is a highly developed follow-up and almoner service, and the Singapore Leprosy Relief Association deals with the rehabilitation of ex-patients in industry and other welfare matters including the care and even adoption of children. In the Federation of Malaya, the famous centre of Sungei Buloh, in addition to its functions of segregation, treatment, and research, provides occupational therapy and surgical treatment including limb fitting. In Fiji, there is an ingenious system of sending sulphones by post in special packages which appears, from the reports, to be highly effective. In Japan, there are 13,091 beds for an estimated total of 15,000 cases.

Among the governments which have shown an interest in expanding the work with WHO/UNICEF assistance is the Federation of Malaya, where a field control programme is to be developed in collaboration with Sungei Buloh; the British Sol-

omon Islands, where this year a WHO consultant will draw up a survey and treatment programme in conjunction with the yaws campaign; China (Taiwan), which is requesting WHO assistance in redesigning the control system; and Vietnam, which has made tentative enquiries along the same lines.

In the five year period ending October 31, 1955, BCG vaccination campaigns against tuberculosis, carried out by governments with WHO/UNICEF assistance, resulted in the tuberculin testing of 12,417,428 persons and the vaccination of 5,885,031, and the work is still continuing. Because there is indirect evidence, though no actual proof, that BCG vaccination has some protective value against leprosy, it is interesting to speculate about the long-term effect on leprosy prevalence in areas where BCG has been widely used. An experimental trial under controlled conditions, to investigate the effects of BCG vaccination on incidence rates of leprosy, is being carried out on Mactan Island in the Philippines by the Leonard Wood Memorial.

Because WHO/UNICEF are assisting mainly, or even wholly, in domiciliary chemotherapy schemes, it must be emphasized that such are not regarded as the be-all and end-all of leprosy control. Institutions are still needed for the isolation and treatment of grossly infectious cases, especially those from households with young children; for lepra reactions during treatment; and for patients so physically deformed or mentally deteriorated that they are incapable of existing in the outside world. Laboratories and research centres are still needed and increasing health education with the right approach. Public health workers are attempting, by trial and experiment, to evolve the best methods of applying the new knowledge to various situations in the Far East; and for this reason, better and better public health administration is also needed, so that the new methods, when evolved, shall be wisely and effectively employed.

Summary of WHO Annual Report for 1955

SOME 400 MILLION PERSONS, one sixth of the world's population, have benefited from modern methods of controlling malaria, tuberculosis, and treponematoses as a result of programs assisted by the World Health Organization.

In seven years of activity, according to the Annual Report for 1955, WHO achieved "substantial results" in the fight against communicable diseases, in the strengthening of national health services, and in training health workers.

The annual report, detailing WHO's services during 1955, was presented by Dr. M. G. Candau, WHO Director-General, to the Ninth World Health Assembly, in Geneva, May 1956.

The period covered by this report was also marked by the following events for the Organization, whose total membership, including associate members, reached 85:

—Over 500 health projects were assisted by WHO in 108 countries and territories.

—A new strategy was decided on by the Eighth World Health Assembly in the fight against malaria, aiming at world-wide eradication of the disease within a definite time limit.

—A turning point was reached in the world outlook on tuberculosis, with the advent of effective new drugs which caused a revolution in the management of this widespread disease. WHO started pilot studies to test the success of home treatment with these drugs. At the same time, BCG campaigns continued, during which some 26 million persons were tested and 10 million vaccinated.

—By the end of the year, 50 million persons had been examined and 15 million treated since the inception of the mass campaigns against yaws and other treponematoses, and the cost had fallen to 75 cents per treatment, 10 cents per examination.

—WHO's atomic program got under way, including such aspects as training of health workers for atomic installations, standardization of radiation units, studies on health problems connected with the siting of reactors, and methods of disposal of atomic wastes.

—The International Sanitary Regulations were in operation for the third year and have now become the health charter of international travel throughout most of the world.

—National health administrations were helped to develop or improve services concerned with sanitation, nutrition, mental health, maternal and child health, nursing, health education, social and occupational health, and dental health.

—Sixty-nine WHO teachers were appointed to 25 schools of nursing. Other WHO teachers were at work last year in medical colleges, schools of public health, and institutes for the training of auxiliary personnel. Nearly 1,000 fellowships were awarded.

—WHO had a budget of $9,500,000 and its financial position was the most favorable since the inception of the Organization. Under the UN Technical Assistance Program, the WHO program amounted to nearly $5,000,000, while UNICEF continued to provide supplies and equipment in generous amounts for a large number of joint projects of benefit to mothers and children.

The Fight Against Disease

Developments in the fight against the world's three major diseases are described at length in the WHO annual report. The most important areas follow:

Malaria. The World Health Assembly, at its meeting last year in Mexico, recommended that nothing short of total eradication should be undertaken on a world-wide scale. This decision was taken because some malaria-carrying mosquitoes are developing resistance to insecticides. The choice was either to continue local attempts to control malaria by spraying year after year, or to launch a full-scale attack aimed at eradication of the infection, so that insecticide spraying could be stopped before resistance on the part of mosquitoes had a chance to develop. A five year plan was drafted, interregional programs of malaria eradication were prepared, and WHO malaria experts were at work last year in the 23 areas.

Tuberculosis. New drugs have caused a revolution in the management of tuberculosis, and traditional methods of treatment are being discarded. The building and maintenance of expensive sanatoria are no longer needed; for the first time, home treatment of infectious cases, mass immunization, and, possibly, preventive treatment with an inexpensive drug, such as isoniazid, may bring systematic control of tuberculosis within the reach of almost any country. WHO's program has been modified accordingly, with emphasis on the making of surveys to obtain reliable information regarding the epidemiology and incidence of tuberculosis and the applicability of simple, practical, and inexpensive control measures. Two research projects on the effects of home treatment of T.b. patients were planned for Southeast Asia. WHO continued to assist T.b. teaching centers in 13 countries, as well as a number of BCG campaigns.

Treponematoses. Yaws, endemic syphilis, and other treponemal diseases continue to respond to penicillin treatment, and impressive results have been obtained in mass campaigns against these infections. They have also served as the starting point of general rural health work in many areas of Africa, Asia and the Western Pacific, and in the Caribbean region.

Rabies, leprosy, poliomyelitis, trachoma, and more than twenty other communicable diseases were also on the WHO program and important developments are reported concerning their control.

Health Services in the Field

In order to achieve lasting results, health work must be carried out by firmly established public health services in every country. It is the principal aim of the World Health Organization to strengthen these services and the annual report gives many examples of progress in this respect on all continents:

Africa. The WHO Regional Office in Brazzaville is especially concerned with the health of the predominantly rural population, and emphasis is placed on basic problems such as sanitation and nutrition. Examples of the work carried out last year also include control of yaws and leprosy in Nigeria, tuberculosis surveys in East and West Africa, sanitation in the Seychelles where intestinal infections are the chief problem, and malaria control in Liberia.

The Americas. The main activities of the Pan American Sanitary Bureau in Washington, which is WHO's Regional Office for the Americas, are: to strengthen national health administrations, to assist in the training of professional and auxiliary health personnel, and to help eradicate communicable diseases. Typical projects include T.b. control in Colombia, rural health work in Guatemala, training in sanitation (Brazil, Chile, Mexico), rabies control (United States and Mexico), while essential work continues for malaria eradication and yellow fever control.

Southeast Asia. WHO's Regional Office in New Delhi seeks to help governments to provide at least the minimum public health services for the 400 million persons (out of a total of 500 million in the region) who live in rural areas in conditions of poverty, ignorance, and disease. Emphasis is laid on sanitation and health education. The enormous burden of diseases is being gradually reduced by means of mass BCG campaigns, as well as malaria and yaws control campaigns. Health workers are needed in hundreds of thousands but there is an acute shortage of teachers to train them. Typical projects last year included a seminar on sewage disposal (in which all countries in the region participated), assistance to the Post Graduate School of Nursing in Indonesia, and BCG vaccination campaigns in India (125 government teams were at work last year. Since the campaigns started in 1951, 57 million have been tested, and 19 million vaccinated up to July 1, 1955; the present average rate is 2.3 million tests and 0.8 million vaccinations per month).

Europe. Co-ordination of national health policies and exchange of information between European countries, as well as training programs, are the main features of the work by the Regional Office in Geneva (which is moving next year to its permanent site in Copenhagen). The majority of programs initiated by this office affect several countries at a time. Chronic degenerative diseases, poliomyelitis, alcoholism, industrial health, and anaesthesiology are among the subjects of these programs. Other typical projects include trachoma control in Morocco, Tunisia, Yugoslavia, and Spain; public health teaching; and mental health.

Eastern Mediterranean. Development of health services, training, and disease control are the aims of the Regional Office in Alexandria, with special emphasis on malaria, trachoma, tuberculosis, smallpox, leprosy, and gastrointestinal infections. Typical projects were a meat hygiene course, attended by representatives of nine countries, a nursing education scheme in Jordan and in Pakistan, tuberculosis control projects in Egypt and Ethiopia, as well as the establishment of a nutrition institute in Teheran.

Western Pacific. From Manila, the Regional Office serves a wide area where local health services are in different stages of development, and where health needs vary accordingly. Sanitation is a grave problem, as is the lack of personnel. Typical projects include midwifery training in Singapore, maternal and child health services in Taiwan, and public health training at the University of the Philippines.

In his introduction to the annual report, Dr. Candau mentioned the following development: "As the result of a statement made by the delegate of the Union of Soviet Socialist Republics to the twentieth session of the Economic and Social Council in the summer, communications were sent to the authorities in the Soviet Union concerning its intention to resume participation in the work of WHO. The resulting developments were favorable enough to make it seem by the end of the year that the universality which has always been considered as essential to the ultimate achievement of the objective laid down in the Constitution was nearer to attainment than it had ever been before."

Salk Polio Vaccine

COMMENTS CONCERNING ADMINISTRATION to ALLERGIC CHILDREN

Jean Crump, M.D.

THE PEDIATRIC DEPARTMENT of The Woman's Medical College of Pennsylvania has been conducting a study on the problem of possible allergic manifestations appearing after the administration of Salk polio vaccine. The preparation used was supplied by Eli Lilly and Company.

A much larger percentage of children were found to be allergic (as evidenced by skin test) than had been anticipated. Approximately 50 percent of the first 150 known allergy cases showed positive skin reaction and 25 percent of these were marked. In the control study of about 125 school children (allergy history not known) from 5 to 7 years of age, approximately 25 percent gave definite local reaction to the vaccine.

Dr. Crump is Professor of Pediatrics, Woman's Medical College of Pennsylvania, Philadelphia.

Although this work is not complete, it seems wise to bring it to the attention of other physicians. Any child exhibiting reactions should definitely be hyposensitized before the first dose is completed.

It appears that if the second dose is given at the end of a three week interval, it can be given without anticipation of any allergic problem. Vaccine given after the three week interval should always be preceded by a skin test.

A number of cases of mild allergic shock and severe urticaria in untested cases have come to our attention. We have no data at present to know whether or not these children came from "allergic families" or not.

1956 EMERGENCY DOSAGE SCHEDULE

Hart E. Van Riper, M.D.

THE ART OF MEDICINE often consists in making reasonable compromises between ideal and real situations. The real situation with regard to the present supply of Salk poliomyelitis vaccine, as it concerns the private practice of many physicians, may often require a compromise with the ideal dosage schedule for the administration of this prophylactic for paralytic poliomyelitis.

I wish to present and reiterate some facts about the Salk vaccine which may help physicians decide most wisely for themselves how they shall use the supplies of vaccine that are available to them.

The following compromise or emergency dosage schedule of Salk vaccine coming into the physician's private practice seems warranted under current conditions of supply, discussed later:

Dr. Van Riper is Medical Director of the National Foundation for Infantile Paralysis.

1. There is minimal risk if, in fact, any at all, in giving primary or booster shots during the polio season.
2. Use all available vaccine immediately. Do not save it for "second shots," even though a sterilely punctured vial of vaccine can be kept under refrigeration for an indefinite length of time without impairing either safety or potency of the vaccine.
3. The increasing supply of vaccine should be depended upon for second injections in 1956. The exact interval recommended between the first and second doses is not critical, so long as it is not less than two weeks. In fact, longer intervals seem to be advantageous. Therefore, the second dose may be given at any time without losing the benefit of the first.
4. However, the third dose should be given not less than seven months after the second, but may be given at any length of time thereafter.

On March 13, 1956, the Surgeon General of the U. S. Public Health Service issued a statement endorsing the postponement of "booster shots" as a temporary measure "to enable more children to receive first or second doses and thus extend protection to more people before this summer's poliomyelitis season."

On the basis of reports from manufacturers and the Surgeon General of the U. S. Public Health Service concerning estimated vaccine production, we have reason to believe that an adequate supply should be available for distribution before the seasonal advent of poliomyelitis in different regions of the United States. How much of this will get into the hands of private physicians is variable, depending on decisions of state and local health authorities and their advisory committees.

If the anticipated supply becomes available, it should be about enough to provide a high degree of protection against paralytic poliomyelitis before the height of the 1956 polio season to all children in the most susceptible age groups (6 months through 14 years) and pregnant women who request it. In round numbers, there are approximately 50 million individuals in these categories. At least 10 and probably 15 million children have already received one or more injections of Salk vaccine. This leaves about 35 million children and some to be vaccinated.

Granting rapid and equitable distribution and no unanticipated delays in processing and releasing vaccine (which requires a minimum of 120 days), we should have just about enough vaccine to give at least one and usually two injections each to 35 million people. Administration of this vast amount of vaccine presents a task of heroic proportions.

The ideal dosage schedule currently recommended is: Two 1 cc. injections, spaced two to six weeks apart, with a third 1 cc. ("booster") injection given not earlier than seven months later. Ideally, the first two injections should be given immediately after the previous polio season, in the late fall, with the booster injection being administered just before the subsequent polio season.

In the future, vaccination against paralytic poliomyelitis undoubtedly will become a standard pediatric procedure, with a schedule of injections beginning at six to nine months of age. But we must face the current situation realistically. The effectiveness of the vaccine depends on the mass of antigen administered and the number and spacing of inoculations.

A compilation of reports from 30 state health officers, evaluating results of the 1955 vaccine program, showed about 79 percent effectiveness even though three inoculations, as recommended, had not been given. This compilation compares experience among 5.2 million unvaccinated children and 4.8 million children who received one or more doses, but mostly one dose, of vaccine. Even under the epidemic conditions that prevailed in Massachusetts in 1955, a high rate of protection (60 percent) against paralytic poliomyelitis was reported from just one dose of the vaccine used in that state.

Other research, still in progress, has revealed this fact: the first injection of vaccine of the potency that prevailed in 1955 did not "take" in about 20 percent of the children inoculated. However, a substantial percentage of those who fail to acquire antibody on the first injection attain antibody, and a primary sensitization, with a subsequent injection.

For a true booster effect, in which antibody reaches very high levels, equal to or exceeding those produced by naturally acquired immunity, the injection following primary sensitization must be delayed at least seven months or longer.

An increasing vaccine supply may be anticipated as the polio season approaches. There will also be a greater public interest in getting vaccination at this time; but because of the time required to induce full immunity, it would be advantageous to give the first dose as early as possible to all within the stated age groups.

PICTURE CREDITS

Pages 235, 241, 245, 248, and 249—Courtesy of World Health Organization, UNATIONS, New York.

Pages 262 and 263—Courtesy of Academic Travel Abroad, Inc., New York, New York.

—Courtesy of Finnish National Travel Service, New York, New York.

—Courtesy of Franz Schneider, Luzern, Switzerland.

—Courtesy of German Tourist Information Office, New York, New York.

Page 268—Courtesy of Joseph Morsello, Philadelphia.

American Medical Women's Association

PRESIDENT'S MESSAGE

THAT OUR POINT OF VIEW CHANGES is a natural process. As children, we look forward to the Fourth of July, because of the fireworks, the sports contests, the picnics, and the general air of festivity. The holiday ushers in the summer in earnest, and with it vacation and fun.

As we grow up, we think of it less as a time of merrymaking. If we have jobs, it is more likely to mean a day off, or if the date comes near a week end, it means a three day holiday! The excitement and bustle of the day frequently cover up the true significance of the celebration. The patriotic orators, who were so prominent years ago, have almost disappeared, and their admonitions have, for the most part, been forgotten. Should we not think of the real meaning of the day? We are celebrating the signing of the Declaration of Independence and with it the actual binding of the 13 separate states into a national unit. There is a deeper significance to the celebration, however. It means the rededication of the country as a whole to the principles of freedom and equality.

Could we not, therefore, as individuals, rededicate ourselves to these basic thoughts? Because of our profession, we are leaders in our respective communities. Whether native born, or adopted children, we are all proud of our American citizenship. Let us therefore, this Fourth of July, resolve again to serve our country to the best of our ability.

Camille Mermod

EQUAL RIGHTS AMENDMENT

At the Annual Meeting of the American Medical Women's Association in Chicago, June 9, 1956, the following motion was passed:

"That each member of the American Medical Women's Association be urged to contact her Congressman supporting the Equal Rights Amendment."

It was pointed out that the Equal Rights Amendment is included in the platforms of both parties, and that support of this Amendment is particularly important now, before the Presidential election.

MWIA COUNCIL MEETING

The attention of all members of the American Medical Women's Association is called to the fact that each member in good standing has the privilege of becoming a delegate to the Council Meeting of the Medical Women's International Association to be held at the Hotel Bürgenstock, Lucerne, Switzerland, September 21 through 23, 1956. It is hoped that several members will avail themselves of this opportunity to attend the meeting. The United States is allowed 5 Councilors and 25 Delegates to represent the AMWA. So far, the Councilors have been chosen, but only about ten Delegates.

If you can go and would like to be a Delegate, please get in touch with the President, Camille Mermod, M.D., 15 Washington Street, Newark, New Jersey, before August 15, 1956.

Opportunities for Women in Medicine

OPENINGS

The Texas State Department of Health announces examinations for director, mental health division (salary range, $9,720-$12,120). The minimum qualifications are 1) an M.D. degree and one year's internship; 2) an M.P.H. degree or certification by the American Board of Psychiatry and Neurology; 3) five years of graduate training and experience in psychiatry or pediatric-psychiatry, including three years of approved training in one of the two fields (the two additional years must be training or exerience in psychiatry, pediatric-psychiatry, or public health. One year of training or experience must include work with children. Preference will be given to those having experience in administering a state preventive mental health program or in the capacity of consultant in such a program); and 4) licensure to practice medicine in Texas. For application write: Merit System Council, 814 Littlefield Building, Austin, or Dr. Henry A. Holle, Commissioner of Health, Texas State Department of Health, 410 E. Fifth St., Austin.

* * *

Applications will be accepted for the newly created position of medical epidemiologist in the Washington State Department of Health. Applicants must be graduates of an approved school of medicine and must have had a one year rotating internship; one year of graduate training in an approved school of public health; and three years of full-time employment in public health work, including one year of experience in some phase of epidemiology. The examination will consist of an evaluation of pertinent training and experience (100 percent). A qualifying interview may also be required. A recent photograph should be submitted with application to State Personnel Board, 1069 Capitol Way, Olympia (Mailing address: P.O. Box 688, Olympia).

* * *

The University of Wyoming is seeking a director for its student health service, since the present director is nearing retirement age. Salary will be approximately $10,000 per annum, with a month's vacation and some other perquisites, details of which may be obtained from Pres. George D. Humphrey, Ph.D., University of Wyoming, Laramie. Wyoming licensure is required.

* * *

Looking for work overseas? Dr. Henry Van Zile Hyde, head of the Public Health Service's International Division, says he has at least 20 jobs in a dozen countries where the U.S. is providing medical aid under the Point Four Technical Assistance Program.

There are openings for chiefs of health missions; public health physicians; professors of epidemiology, parasitology, microbiology, internal medicine, and preventive medicine; a medical education adviser; and a research adviser. The countries include Afghanistan, Iran, India, Libya, Korea, Thailand, Taiwan, Egypt, Haiti, Honduras, Jordan, Iraq.

RESEARCH AWARDS

Applications by research investigators for support of studies in or related to the cardiovascular field are now being accepted by the American Heart Association. The awards would be for the fiscal year beginning July 1, 1957. Application deadline for research fellowships and established investigatorships is September 15, 1956. For grants-in-aid, applications must be made by November 1, 1956. Awards are made in these categories:

Established Investigatorships. Awarded for periods of up to five years, subject to annual review, in amounts ranging from $6,000 to $9,000 per annum, to scientists of proven ability who have developed in their careers to the point where they are independent investigators.

Research Fellowships. Awarded to young men and women with doctoral degrees for periods of one to two years to enable them to train as investigators under experienced supervision. Annual stipends range from $3,500 to $5,600.

Grants-in-Aid. Made to experienced investigators in varying amounts up to $10,000 to provide support for specified projects.

The Association also maintains another and unique form of research support, the Career Investigatorship. This is given to a limited number of scientists of unusual capacity and accomplishment to assure them of financial support throughout their productive lives. Career Investigators are selected on the initiative of the Heart Association Research Committee and not from applications.

Further information and application forms are available from the Medical Director, American Heart Association, 44 East 23 Street, New York.

* * *

The State University of New York College of Medicine in Brooklyn has received a grant of $24,000 from the Josiah Macy Jr. Foundation to support student research scholarships in the field of reproduction. The money will be divided into

five awards of $4,800 to provide eight Josiah Macy Jr. Foundation Scholarships each year. Student scholarship winners will receive $500 each. The balance will be used for laboratory expenses. Scholarship winners will be selected by a faculty committee representing members of both the basic and the clinical sciences. Dr. Louis M. Hellman, head of the department of obstetrics and gynecology, is chairman of the committee.

FELLOWSHIPS

Fellowships and scholarships offered by the National Foundation for Infantile Paralysis are described in a brochure issued by The Division of Professional Education of the Foundation.

Postdoctoral fellowships are offered in medicine and the related biologic and physical sciences, preventive medicine, rehabilitation, orthopedics, management of poliomyelitis, and psychiatry.

Fellowships in medical associate fields include those in social sciences, health education, physical therapy teaching, physical therapy travelships, and occupational therapy teaching. Scholarships are offered in physical therapy and medical social work.

Information may be obtained from The Division of Professional Education, National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York.

* * *

A fellowship in allergy available at Northwestern University Medical School provides a combination of clinical and investigative work in allergy for training in specialization and is approved for credit by the Board of Internal Medicine and the Subspecialty Board of Allergy. The annual stipend is $3,000. A residency in allergy available at the Veterans Research Hospital provides for service equally divided at the hospital and the medical school. For details write to Dr. Samuel M. Feinberg, Northwestern University Medical School, 303 E. Chicago Ave., Chicago 11.

* * *

A three year fellowship program designed for staff psychiatrists in public mental hospitals and schools for the retarded has been announced by the American Psychiatric Association and the Smith, Kline & French Foundation of Philadelphia. From 6 to 12 fellowships will be awarded under a $90,000 grant by the Smith, Kline & French Foundation. Applicants are expected to submit a "fellowship project" entailing education, training, and experience in any of a number of specialties to the fellowship committee of eight psychiatrists. Details of the fellowships may be obtained from Smith, Kline & French Fellowship Committee, American Psychiatric Association, 1785 Massachusetts Ave., N. W., Washington 6, D. C.

* * *

The University of Texas M. D. Anderson Hospital and Tumor Institute announces that facilities and equipment for therapy and research in the field of malignant diseases are provided for qualified applicants seeking training and research opportunities in oncology. Fellowships and residencies are under the auspices of the University of Texas Postgraduate School of Medicine. For information write to Dr. Grant Taylor, Office of Education, University of Texas M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston 25, Texas.

* * *

The Department of Pediatrics of The Ohio State University and The Children's Hospital of Columbus, Ohio, announces the establishment of a Clinic of Child Development, which will concern itself with deviations from normal behavioral development in the preschool period from birth through 5 years. In addition to diagnostic evaluation, guidance in the management of problems and help in securing the necessary medical and community services will be provided.

Fellowships for a period of one year, with a stipend of $5,000, are available beginning July 1, 1956, with one position each six months provided. Pediatricians who are trained will have opportunities to engage in research projects designed to elucidate the etiologies of the neuropsychiatric disabilities of childhood and to enter into the teaching program.

Address inquiries to Dr. Earl H. Baxter, Chairman of the Department of Pediatrics, The Ohio State University, or to Dr. Hilda Knobloch, Associate Professor of Pediatrics and Director of the Clinic, Columbus, Ohio.

* * *

The National Foundation for Infantile Paralysis will continue to offer a number of fellowships to provide educational opportunities for health educators employed in state departments of education or of health. Applicants must have obtained their bachelor's or higher degree from an accredited institution and have had substantial training in biological science and education or other social sciences. Only those who have had a minimum of two years of experience as educators in the field of health will be eligibile. Citizenship in the United States as well as sound health are prerequisites. The program of study may be undertaken at any school of public health in the United States that offers a graduate program in health

education and is approved by the American Public Health Association. The candidate must make his own arrangements with the institution for a program of study and field training to supplement his previous background and to prepare him more adequately for the responsibilities of a health educator. Financial assistance will be given for tuition and maintenance, depending on individual need as determined by marital status and number of dependents. Applications may be submitted at any time, but for consideration in May they must be received by March 1; for action in November by Sept. 1; and for consideration in February by Dec. 1. For information address: Division of Professional Education, National Foundation for Infantile Paralysis, 120 Broadway, New York 5.

MEETINGS

A tentative program has been outlined for the thirty-second annual meeting and twenty-ninth scientific session of the American Heart Association to be held in Cincinnati, October 26-31, 1956. The scientific sessions will be conducted at the Music Hall auditorium beginning on Friday evening, October 26, and continuing through Monday, October 29. The organizational meetings of the Association will follow the scientific presentations.

For further information write the American Heart Association, 44 East 23rd Street, New York 10, New York.

* * *

For the first time in its 35 year history, the National Society for Crippled Children and Adults will hold its annual convention at the nation's capital in 1956.

The four day meeting of the National Society, also known as the Easter Seal Society, which will be held Oct. 28-31, 1956, will highlight speeches by notable authorities in rehabilitation and feature displays of newest appliances for crippled children and adults. General sessions are planned for the mornings of the convention. Afternoons will be devoted to workshops, seminars, and institutes covering many phases of rehabilitation.

For further information write Catharine Bauer, Director of Information, Development Service, The National Society for Crippled Children and Adults, 11 S. LaSalle Street, Chicago 3, Illinois.

FOR SALE

Practice and doctor's house are for sale. This is general practice and office gynecology, appointments and office hours; an excellent local practice. Doctor is moving out of town. Reasonable price. Write Dr. Elly Stern, One North Seventh Street, New Hyde Park, Long Island, New York, PRimrose 5-8361.

THESE WERE THE FIRST

Dr. Leona Baumgartner, graduate in 1934 of the Yale University School of Medicine, interned in the New York Hospital. The following year, Dr. Baumgartner was acting assistant surgeon, United States Public Health Service, and in 1938-1939 was director of public health training in the City of New York's Department of Health. She spent 12 years in this department. In 1940, she was associate chief, United States Children's Bureau, and for eight years director of the department, Bureau of Child Hygiene. In 1947, Dr. Baumgartner received the distinguished service award from University of Kansas alumni. She is now Commissioner of Health, New York, the first woman to be so honored.

Dr. Annie L. Alexander graduated from the Woman's Medical College of Pennsylvania in 1884, and is thought to have been the first woman physician to have practiced south of the Potomac. She taught anatomy at the Woman's Medical College of Baltimore and was the only woman among 100 candidates to take examinations for license to practice in Maryland before the State Board of Medical Examiners. Dr. Alexander practiced in Charlotte, North Carolina, and was president of the Mecklenburg County Medical Society and during World War I was acting assistant surgeon at Camp Greene.

Dr. Dorothy Harris, graduate of the Woman's Medical College of Pennsylvania in 1933, was the only woman on the staff of the leprosarium in Lanchow, China, directed by the China Inland Mission. After a visit to this country, Dr. Harris returned in 1947 to her work in China.

Dr. Maria W. Porter of Davenport, Iowa, is the first woman physician known to have practiced in Iowa, and perhaps the first west of the Mississippi River. In 1859, Dr. Porter graduated from the Woman's Medical College of Pennsylvania.

Dr. Delia S. Irish, of Davenport, Iowa, was the first woman physician to be admitted to the Iowa State Medical Society, and was a pioneer medical woman in her state. Dr. Irish graduated from the Woman's Medical College of Pennsylvania in 1868.

—From the Elizabeth Bass Collection
Rudolph Matas Medical Library, Tulane University.

Lillie Rosa Minoka Hill, M.D.

IN THE CLASS OF 1899 of the Woman's Medical College of Pennsylvania was a little Mohawk Indian girl. She was Lillie Rosa Minoka who was reared by Quakers in Philadelphia.

After interning at Woman's Hospital, she opened her office on North Nineteenth St. in Philadelphia and practiced there for five years. She left in 1905 when she married Charles Hill, a full-blooded Oneida Indian from the Carlisle, Pennsylvania, Indian School. They went to live on the Oneida Reservation in Wisconsin. In deference to her husband's wishes, she withdrew from regular practice, but he did want her to attend to neighbors and relatives. She devoted her skill and knowledge to the ailing poor.

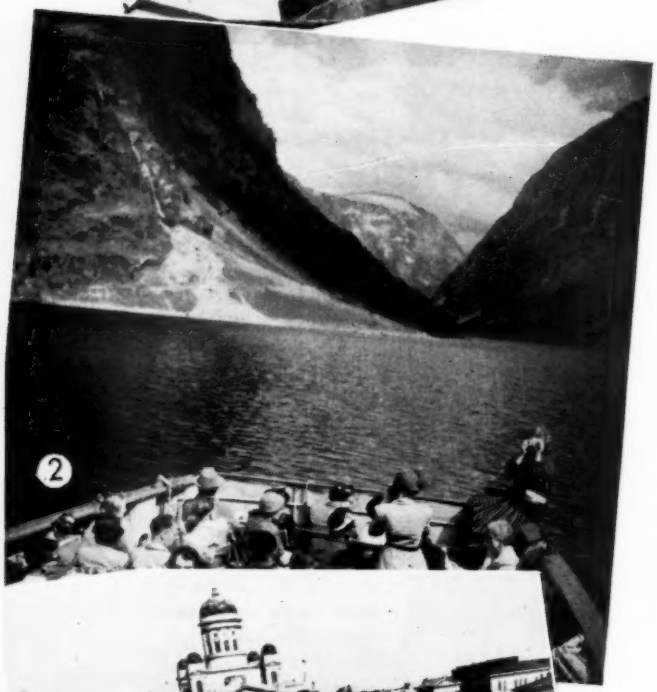
Dr. Hill's husband died in 1916, and she was left with six children, the youngest 5 month old twin girls. Life became a struggle, but she continued to minister to the sick poor. A small trust estate was wiped out during the depression. Then in 1934, 35 years after graduation, she applied for a license to practice medicine in the state of Wisconsin, and opened an office.

In 1947, she received the Indian Achievement Award for "personal achievement and for humanitarian service to her people." It was after World War I that there was much suffering, illness, and privation among the Oneida Indians, and Dr. Lillie worked day and night to help them. For this great work, and for the many other services she had rendered to her people, she was given the Indian Achievement Award and named the most outstanding Indian of 1947. This honor was given by the Indian Council Fire, an Indian organization in Chicago, affiliated with the Illinois Federation of Women's Clubs.

In 1949, she returned to her Alma Mater where she was honored as a 50 year graduate of Woman's Medical College. When she was interviewed on this occasion, Dr. Lillie said, "The precepts and training of the Quakers had awakened in me a desire to do good, a love of God and of my neighbors. While in college, I resolved to spend some time and effort to help needy Indians. In Wisconsin I found my work." She is appreciated by those she served. Among the Oneida Indians who live near Green Bay, Wisconsin, Dr. Hill is known reverently as "You-da-gent" which means, "she who carries aid." The title was given to her by the Oneidas, who adopted her, in grateful appreciation of her 40 years of devoted medical care. Dr. Lillie gave unselfish service not only to Indians but to many whites as well. In howling blizzards and under a blazing summer sun, she has carried her little black bag to deliver babies, apply tourniquets to severed arteries, and to tend the sick.

A life devoted to charity and to the care of the sick came to a close on March 22, 1952. She lived up to the name You-da-gent.

—MARCELLE BERNARD, M.D.



Medical Women's

1956 International

An International Tour is being arranged in conjunction with the MWIA Council Meeting which will be held in Burgenstock, Switzerland, from September 21 to 24, 1956. The Tour will visit the Scandinavian countries (including Iceland and Finland), and Luxembourg. If circumstances permit, an Western Germany, Switzerland, Alsace-Lorraine, alternative itinerary to include Moscow and Berlin can be arranged. Although much ground will be covered, the trip will not be arduous, since most of the travel will be by special bus; which will eliminate the bother of meeting train schedules, the nuisance of baggage transfer, and other travel annoyances. Travel by bus also permits visits to many places which cannot be included on train routes, and allows the travelers to see more of the native countryside. There will be a courier to manage accommodations, customs, visas, and similar necessary details.

The Tour begins on August 31, 1956, with flight from Idlewild, New York, via Icelandic Airlines to Reykjavik, Iceland (1), for a day of sight-seeing and a night in the Arctic Circle; then by plane to Oslo and a four day trip through the Norwegian fjords (2) by boat and special bus; across Sweden to Stockholm; from which the Tour will proceed to Turku, Finland, by overnight boat, by bus to Tampere, and a boat ride on the "Silver Route" to Aulanko for the night; the next morning to Helsinki (3) for two days, then back to Stockholm by overnight boat and a day of sight-seeing; thence by boat train to Denmark and Copenhagen (4). From this point on, there will be a special bus which will transport the Tour members to Lucerne, Switzerland, by way of Hamburg (5), Hanover, Cassel, Frankfurt, Heidelberg, Baden-Baden, the Black Forest, and Konstanz, stopping for meals and overnight at interesting spots along the way. After Konstanz, the Tour will continue by bus to Zurich and Lucerne, arriving on the evening of September 20 for the MWIA meeting at Burgenstock the following day (6).

International Association

Tour 1956

After the Council Meeting, the Tour will be resumed with a trip over the Alps to Interlaken, and by special bus along the Lake of Thun to Bern and to Basel. From Basel, it will go through Alsace-Lorraine to Strasbourg and then to Luxembourg, where the plane via Iceland will be taken for the return trip to New York, arriving on the morning of October 1.

For those who prefer to cross the Atlantic by boat, individual arrangements will be made so that the travelers by sea will meet the travelers by air in Oslo. Also, on th ereturn trip, transportation from Luxembourg back to New York via Brussels, Paris (Havre), or other ports will be arranged according to the desires of the individual.

The alternative trip to USSR will begin with a plane trip from Helsinki (September 11) to Leningrad and to Moscow for a two to three day visit; then by plane to Berlin for a day and a night, leaving for Frankfurt by plane to rejoin the group for travel to Heidelberg.

On the Tour, places of medical interest will be visited and meetings will be held with the medical women of the country. Members of the Tour having preferences for special clinics or hospital visits will be put in touch with similar specialists in the country being visited. Final arrangements will depend on the number in the party and on their special interests. Friends and husbands are invited to participate. It will be greatly appreciated by the organizer of the Tour and the agency making the arrangements if those expecting to take the Tour will communicate with us as soon as possible so that we may make the most agreeable arrangements and provisions for individual interests.

If interested, please write for details as soon as possible to Ada Chree Reid, M.D., Past President, MWIA, 118 Riverside Drive, New York 24, New York. The Association for Academic Travel Abroad, Inc., Dr. F. Kaufman, Director, 40 East 49th Street, New York 17, New York, will handle travel arrangements and reservations.

News of Women in Medicine

DISTRICT OF COLUMBIA. Dr. Edith H. Weigert, Dr. Leon Salzman, and Dr. Hewitt I. Varney participated in a lecture series devoted to "The Interrelationship Between Religion and Psychiatry," sponsored by the Washington School of Psychiatry and the Washington Seminar on Religion and Psychiatry.

Dr. Weigert, who is director of the Washington Psychoanalytic Institute, spoke at the second session, January 20, at All Souls Church, on "The Psychopathology of Religious Experience."

GEORGIA. Dr. Harriet E. Gillette of Atlanta was awarded the entire stipend of $1,000 of the Richard Kovacs Memorial Fellowship Fund. This fund was established in 1952 to help defray the expenses of a qualified physician wishing to attend the Second International Congress of Physical Medicine, August 20 to 24, 1956, at Copenhagen, Denmark, and is given by the American Congress of Physical Medicine and Rehabilitation.

ILLINOIS. Recently, the Chicago Pediatric Society was addressed by Dr. Isabel Lai-Fong Szeto and Dr. Heyworth N. Sanford on "Alkaline Resistant (Fetal) Hemoglobin in Infancy and Childhood"; and by Dr. Mila Pierce on "Treatment of Childhood Leukemia."

MINNESOTA. Dr. Ann W. Arnold has been elected president and chief of the medical staff of Ripley Memorial Hospital (formerly Maternity Hospital), Minneapolis. Other staff officers include Dr. E. J. Diefenbach, vice-president; Dr. Marie Moorhead, secretary; and Dr. Annette Stenstrom, treasurer.

NEW JERSEY. Dr. Katharine H. Hain of Upper Montclair has been appointed to the staff of medical writers of Schering Corporation. Dr. Hain was for two years chief of the Bureau of Heart Disease, New Jersey State Department of Health, in Trenton, where she initiated a state-wide rheumatic fever program. Previously, she had served for five years as assistant pediatrician in the outpatient department of New York Hospital-Cornell Medical Center, and was a Fellow in pediatrics at that institution. Dr. Hain is board qualified in the specialty of pediatrics.

Dr. Hain is a graduate of Barnard College, Teachers College, Columbia University, and the Woman's Medical College of Pennsylvania. She is a member of Alpha Epsilon Iota, professional medical women's society. Dr. Hain is also a member of the Essex County Medical Society and regional representative for the Woman's Medical College. Her husband is Donald C. Hain, a lawyer.

NEW YORK. A medical symposium on alcoholism was presented by the New York City Medical Society on Alcoholism on May 10, 1956. "Practical Management of the Alcoholic" was discussed by Dr. Ruth Fox, president of the society, and vice-president, The National Committee on Alcoholism.

PENNSYLVANIA. Temple University School of Medicine announces the following staff appointments: Dr. Margaret N. Dealy, instructor in psychiatry, and Dr. Nancy N. Huang, associate in pediatrics.

Dr. Elizabeth Q. St. John, Feasterville, has been named associate medical director of the Fidelity Mutual Life Insurance Company. Before joining the company's medical department in 1933, Dr. St. John was associated with the Food Research Laboratory, U.S. Bureau of Chemistry. From 1911 to 1925, she was clinical pathologist of the Dufur Hospital, Ambler.

General

Dr. Alma Dea Morani of Philadelphia is secretary of the Philadelphia subsidiary board of the National Board of Medical Examiners, and Dr. Enid K. Rutledge is secretary of the Denver subsidiary board.

A newly revised edition of the booklet, "Diagnosis of Cardiac Defects in General Practice," has been prepared for the American Heart Association by Dr. Regina Gluck, assistant clinical professor of pediatrics at Bellevue Hospital, New York. The revision reflects the many advances in knowledge and in clinical experience with regard to diagnosis, management, and treatment of congenital defects since the issuance of the prior edition in November 1954. Particular attention is paid to the most recent developments in surgical correction of congenital anomalies.

Dr. Ruth Rhines, formerly associate in medicine, University of Pennsylvania School of Medicine, Philadelphia, has been appointed associate professor of anatomy in the University of Chicago division of biological sciences. Dr. Rhines previously served as instructor in medicine at the University of Illinois College of Medicine and assistant superintendent of the Municipal Contagious Disease Hospital in Chicago.

Dr. Lucie W. Jessner, professor of psychiatry, University of North Carolina School of Medicine, Chapel Hill, flies to Washington, D.C., bimonthly to teach at the Washington Psychoanalytic Institute. Dr. Jessner holds a seminar on child development at the institute.

Letters TO THE EDITOR

(The JOURNAL reaches medical women around the world each month. We are happy to publish excerpts from several letters received concerning the World Health Organization special number that appeared in July 1955 . . . . Ed.)

I apologise for not writing sooner to say how much I have appreciated your JOURNAL (July 1955) with its most valuable contents. I have given up consulting practice so do not require the stimulus of good reading. My time is occupied with a reduced staff and also am engaged in endeavoring to write accounts of my medical life. With all my thanks and congratulations on the eminence of your JOURNAL.

—DAME A. LOUISE MCILROY
London, England

Thank you very much for your letter and the copies of the July JOURNAL. I would like to congratulate you on this occasion on the interesting and beautiful JOURNAL you are publishing.

—DR. YONA RUBINSTEIN
Tel-Aviv, Israel

Thank you for your JOURNALS which I recently received. They are extremely interesting. I have posted them on to the secretaries of all of our state societies.

—DR. DOROTHEA HEITMANN
Torrensville, South Australia

The articles of this issue, and of all issues of the JOURNAL, interest me very much, and provide invaluable lessons for me.

—DR. MERCEDES HEUREAUX
New York, New York

I have received the copies of the JOURNAL of July 1955 . . . Being especially the World Health Organization number with an article with reference to India, it is all the more interesting and valuable to us here. Thank you very much indeed. I have distributed the copies to the various divisions of our Association in the country and to the women's hospitals, where the JOURNAL will certainly be much appreciated.

—DR. O. SALDANHA
Bombay, India

Thank you very much for sending me the copies of the July JOURNAL. We are mostly interested in all the work done by WHO . . . We agreed upon who should have the copies and asked them to send them forward to other colleagues.

—DR. ESTRID GULDBERG
Oslo, Norway

Many thanks for your news dated July 20 and for the copies of the July numbers of the JOURNAL which just arrived. We are pleased to distribute these copies to some members of our Association most interested in medical women matters and in the World Health Organization.

Did nobody of your editorial board or of your fellow editors come to Europe and especially to Switzerland this summer? Do you perhaps think this is President Eisenhower's year to come to Switzerland and the medical women do not come over before 1956? Hoping to see you some day in our country.

—DR. ILSE SCHNABEL
Zurich, Switzerland

Many thanks for your kind letter . . . accompanying a copy of the JOURNAL in which is published my article on onchocerciasis. You do not have to thank me for submitting it for publication in your JOURNAL, and it is I who feel grateful for having had, through your JOURNAL, the opportunity of calling attention to a problem which affects about 19,000,000 people in Africa and America. Enough is still not known as to its real extent in South America, but it is a matter to which I have given a lifetime of interest . . .

I am convinced that, thanks to the standing of your JOURNAL and its wide circulation, very useful results can be achieved by stimulating increasing interest in fields where it is so much needed.

—DR. M. GIAQUINTO
World Health Organization

It is very kind of you to send us the copies (of the JOURNAL). I shall circulate them among the members of the Chinese Medical Women's Association. I am sure all of us will enjoy reading them. Please accept our deepest appreciation.

—DR. CHANG-SUNG FAN
Taipei, Taiwan, China

Many thanks for the copies of your July JOURNAL. I find it very interesting, especially as it is the World Health Organization number.

—DR. GRETE ALBRECHT
Hamburg, Germany

Thank you for sending us copies of your July JOURNAL. I am sure our members will appreciate your kindness.

—DR. RUTH WEGELIUS
Helsinki, Finland

NEW ADDRESSES

January 1, 1955, through April 30, 1956

Emma M. Ackerman, M.D.—3739 Jones, Sioux City 9, Iowa.

Anne Stephenson Adams, M.D.—43 White Lane, Concord, N. Carolina.

Capt. Fae Adams, M.D.—Walter Reed Army Hospital, Massage Center, Washington 12, D.C.

Clara M. Ambrus, M.D.—239 Brantwood Rd., Buffalo 21, N.Y.

Ellen E. Ferengul Anspach, M.D.—Nashua, Iowa.

Dorothy W. Atkinson, M.D.—11651 Brooks Rd., Windsor, Sonoma Co., Calif.

Hazel M. Barger, M.D.—c/o Box 1511, Phoenix, Arizona.

Amy S. Barton, M.D.—Wagush Trail, Medford Lake, N.J.

Frieda Baumann, M.D.—Woman's Medical College of Pennsylvania, Philadelphia 29, Pa.

Helen W. Bellhouse, M.D.—12 Capital Square, S.W., Atlanta, Ga.

May Hudson Bennett, M.D.—5058 Jenkins Arcade, Pittsburgh 22, Pa.

Hazel J. Berglund, M.D.—R. Box 160, Loma Luido, Calif.

Louise Bewersdorf, M.D.—R. 2, Box 253, Scottsdale, Ariz.

Nancy Blades, M.D.—2767 Eugenie Lane, Cincinnati 11, Ohio.

Janet M. Boog, M.D.—522 Neff Lane, Grosse Pointe, Mich.

Viola G. Brekke, M.D.—250 Highland, Apt. 302, Highland Park 3, Mich.

Dorothy Brinsfield, M.D.—1463 S. Gordon St., S.W., Atlanta, Ga.

Winifred Bronson, M.D.—140 E. 54th St., New York 22, N.Y.

Lyla I. Brown, M.D.—1538 Sherbrooke St. W., Montreal, Quebec, Canada

Marion R. S. Brown, M.D.—236 West Main St., Meriden, Conn.

Rosemary Brunnetti, M.D.—2222 Garfield Ave., Carmichael, Calif.

Florence R. Buky, M.D.—3400 Thorndale Ave., Chicago 45, Ill.

Minnie B. Burdon, M.D.—Rt. 1, Indio, Calif.

Margaret V. Burns, M.D.—266 Hillside, Asheville, N. Carolina

Almina N. Cameron, M.D.—14464¼ Dickens, North Hollywood, Calif.

Dolores Canals, M.D.—Point House, 974 Blvd. East, Weehawken, N.J.

Marguerite Louise Candler, M.D.—3092 Argonne Dr. N.W., Atlanta 5, Ga.

Esther Silveus Carlson, M. D.—605 Commonwealth Ave., Boston 15, Mass.

Dorothy Case-Blechschmidt, M.D.—8610 Dufferin Ave., Riverside, Calif.

Amey Chappell, M.D.—3391 Peachtree Rd. N.E., Atlanta 5, Ga.

Ruth E. Church, M.D.—400 S. Spring, Springfield, Illinois.

Helen Clark, M.D.—10317 Hedgeway, Dallas, Tex.

Edith Seville Coale, M.D.—305 The Presidential Apts., 1026 Sixteenth St. N.W., Washington, D.C.

Anna Beth Connell, M.D.—P.O. Box 395, Lufkin, Texas.

Jean Corwin, M.D.—70 Haven Ave., New York, New York.

Jean Crump, M.D.—3300 Henry Ave., Philadelphia 29, Pa.

Naomi L. Dalton, M.D.—University of Mississippi, Medical Center, Jackson, Miss.

Alice Hall Davis, M.D.—264 Highland, Hammond, Indiana.

Jessie L. P. Delpratt, M.D.—295 Lansdale, San Francisco, Calif.

Marie A. DeLuca, M.D.—Wrentham State School, Wrentham, Mass.

Primitiva D. Demandante, M.D.—1322 N. Avalon Blvd., Wilmington, Calif.

Helen D. Denniston, M.D.—120 Broadview Ave., Winter Park, Fla.

Geraldine L. Dickinson, M.D.—10032 Roads End Dr., Garden Grove, Calif.

Osee May Dill, M.D.—1625 Jasmine St., Orlando, Florida.

Patricia Dunklee, M.D.—931 W. Chase, El Cajon, California.

Ann Margaret Allen Durand, M.D.—3613 Norton Place, N.W., Washington 16, D.C.

June Dvorak, M.D.—2235 Overlook Rd., Cleveland Hts. 6, Ohio

Lena F. Edwards, M.D.—27 15th St. S.E., Washington, D.C.

Lillian J. Ellefson, M.D.—Cascade Sanatorium, Redding, Calif.

Bertha W. Ellis, M.D.—Box 216, Port Blakely, Washington.

Lena M. English, M.D.—Veterans Administration Hospital, Togus, Maine

Louise M. Camel Farrage, M.D.—478 Elmwood, Council Bluffs, Iowa

Pacita R. Feliciano, M.D.—Community Clinic, Philippine American Life Homes, Quezon City, P.I.

Miriam H. Field, M.D.—32 Park St., Brookline 46, Massachusetts.

Rita S. Finkler, M.D.—35 Leslie St., Newark, N.J.

Elizabeth R. Fischer, M.D.—10401 S. Bell, Chicago 43, Ill.

Joan Fleming, M.D.—664 N. Michigan Ave., Chicago 11, Ill.

Leona R. Fordon, M.D.—1942 East Ave., Berwyn, Illinois.

Vernelle Fox, M.D.—1293 Peachtree St. N.E., Atlanta, Ga.

Thelma Edna Frank, M.D.—1314 16th St., Corpus Christi, Tex.

Gertrude Flint Frisbie, M.D.—200 Liberty St., Lowell, Mass.

R. Eloise Fusca, M.D.—202 Seminary Ave., Towson 4, Md.

Lila J. Gairns, M.D.—c/o Dept. of Anesthesiology, The Albany Hospital, Albany, N.Y.

B. Shannon Gallaher, M.D.—Medical College of Georgia, Augusta, Ga.

Adeline B. Gauger, M.D.—1121 N. Waverly Pl., Apt. 405, Milwaukee, Wis.

Anna E. Gaydos, M.D.—6023 McCallem St., Philadelphia 44, Pa.

Anita Peck Gilger, M.D.—6500 Skyview Dr., Independence 9, Mo.

Beryl Seike Graham, M.D.—2031 Buttner Rd., Pleasant Hill, Calif.

Genevieve A. Grotz, M.D.—861 Monroe Ave., Dearborn, Mich.

Grace Hughes Guin, M.D.—1723 N. Veitch St., Apt. 12S, Arlington 1, Va.

Sybil D. Haire, M.D.—5221 E. Arbor Rd., Long Beach 11, Calif.

Goldie Suttle Ham, M.D.—1813 A. Crawford, Houston, Tex.

Frances Harding, M.D.—3660 Westerville Rd., Columbus 11, Ohio

Margaret E. Hatfield, M.D.—9 West Walworth, Elkhorn, Wis.

Katharine Hawley Martin, M.D.—429 Main St., Watertown, Conn.

Helen Heinen, M.D.—9500 S. 50th Ct., Oak Lawn, Illinois.

Mary K. Helz, M.D.—551 Medical Arts. Bldg., Pittsburgh, Pa.

Sophie B. Hirsch, M.D.—262 Central Park West, New York 24, N.Y.

Marian Hochhalter, M.D.—402 Barnes Bldg., Logansport, Ind.

Maria K. Hoefer, M.D.—55 East 80th St., New York 21, N.Y.

Mary Sabo Hoffman, M.D.—7431 Midbury Dr., Dallas, Tex.

Marianna Hood, M.D.—3707 Gaston, Dallas, Tex.

Barbara Hunt, M.D.—Ewell, Md.

Bertha L. Isaacs, M.D.—2821 North Pine Grove, Chicago 14, Ill.

Dorothy S. Jaeger-Lee, M.D.—3825 Wieuca Rd. N.E., Atlanta, Ga.

Vita R. Jaffe, M.D.—8218 Wisconsin Ave., Bethesda 14, Md.

Harriet D. James, M.D.—1960 Commonwealth Ave., Brighton, Mass.

Mary H. Jennings, M.D.—5266 Maymont Dr., Los Angeles 43, Calif.

Helen Johnston, M.D.—6008 Ronwood Dr., Des Moines 12, Iowa

Isabel Essig Jones, M.D.—910 Hilldale Ave., Berkeley 8, Calif.

Paula Raines Kaiser, M.D.—4015 Bradley Lane, Chevy Chase 15, Md.

Charlotte Kerr, M.D.—728 S. Ashland Ave., Chicago 7, Ill.

Janith Stewart Kice, M.D.—Garden City Medical Center, 520 Franklin Ave., Garden City, N.Y.

Cora Davis Kingston, M.D.—103 Wallace Ave., Covington, Ky.

Elizabeth Z. Kleinmann, M.D.—66 Perkins St., Jamaica Plain, Mass.

Agnes C. Kolb, M.D.—30 Lenon Dr., Little Rock, Arkansas.

Pearl V. Konttas, M.D.—1621 Austin Way, Box 1374, Santa Rosa, Calif.

Hanna Kosterlitz, M.D.—4115 University Way, Seattle 5, Wash.

Maria K. Kramer, M.D.—5310 S. Woodlawn, Chicago 15, Ill.

Ursula Maria Leden Krusen, M.D.—3500 Colgate, Dallas 5, Tex.

Masako Kusayanagi, M.D.—233 Fairmont Ave., Oakland, Calif.

Rose Lahman, M.D.—663 West Peachtree St. N.W., Atlanta 8, Ga.

Eva Landsberg, M.D.—19 Alfasi St., Jerusalem, Israel

Ruth Merrell Lapi, M.D.—2012 Stratford Rd., Kansas City 13, Mo.

Pauline McConnell Lehman, M.D.—P.O. Box 216, Garden Grove, Calif.

Eileen M. Leonard, M.D.—1572 Church St., San Francisco 14, Calif.

Margaret L. Littler, M.D.—85 Center Ave., Pittsburgh 2, Pa.

Lois G. Lobb, M.D.—6541 Homewood Ave., Hollywood 28, Calif.

Gladys Z. London, M.D.—19th and Providence Ave., Chester, Pa.

Miriam Luten, M.D.—308 Taylor St. Bldg., 919 S.W. Taylor, Portland 5, Ore.

Dorothy Reed Cornelia Lynn, M.D.—2239 N. Broad St., Philadelphia 32, Pa.

Dorothy J. Lyons, M.D.—1233 N. Vermont, Los Angeles, Calif.

Ruth McClure, M.D.—513 Campbell Hill St., Marietta, Ga.

A. Genevieve McEldowney, M.D.—St. Elizabeth's Hospital, Washington 20, D.C.

Mary McKibbin-Harper, M.D.—550 Bigelow St., Pittsburgh 7, Pa.

Helen Mackler, M.D.—Respiratory Center, Hondo, Calif.

Margaret R. Harte Madden, M.D.—16 Laurel Rd., New Britain, Conn.

Helen M. Magly, M.D.—4221 Grove Ave., Cincinnati 12, Ohio

Lucille J. Marsh, M.D.—10301 Montrose Ave., Bethesda, Md.

Dorothy H. Marvin, M.D.—3 High St., New Brunswick, N.J.

K. Virginia Maurer, M.D.—21 Kenwood Place, East Orange, N.J.

A. Maximova-Kulaev, M.D.—516 Sutter St., San Francisco, Calif.

Lucille B. May, M.D.—2615 22nd St., Bakersfield, California.

Jeanne Kehoe Mercer, M.D.—322 So. Cuyler Ave., Oak Park, Ill.

Alice B. Mijanovich, M.D.—113 West Washington St., Marengo, Ill.

Helen Miller, M.D.—116 East 66th St., New York 21, N.Y.

Mary Ghormley Miller, M.D.—12921 Woodbury Dr., Orange, Calif.

Ruth Miller, M.D.—Box 1181, Las Vegas, N.M.

Elizabeth R. Miner, M.D.—301 S. Randolph St., Macomb, Ill.

Sophie Mishelevich, M.D.—4651 E. 9 Mile Rd., Van Dyke, Mich.

Dorothy Helen Rieser Misrahy, M.D.—5688 Access Rd., Page Manor, Dayton, Ohio

Olive I. Moe, M.D.—20 West Elm, Stockton 4, California.

Hallie Buchanan Mont, M.D.—4835 Van Nuys Blvd., Sherman Oaks, Calif.

Barbara Moulton, M.D.—5132 Bradley Blvd., Bethesda 14, Md.

Nina T. Mueller, M.D.—1640 South 24th St., Milwaukee, Wis.

Belle P. Nair, M.D.—9 Dunnder Dr., Summit, N.J.

Virginia S. Narbutt, M.D.—2940 Logan Blvd., Chicago, Ill.

Elizabeth Nesbitt, M.D.—Box 215, North Jersey Training School, Little Falls, N.J.

Evelyn A. Rinaldo Newfeld, M.D.—125 East 111th St., Chicago 28, Ill.

Mary Louise Newman, M.D.—814 W. State St., Jacksonville, Ill.

Bertha Offenbach, M.D.—51 Homer St., Newton Center, Mass.

Marie Ortmayer, M.D.—2142 S. High St., Apt. 211, Denver 10, Colo.

Louise Pearce, M.D.—Trevenna Farm, R.D., Belle Mead, N.J.

Carolyn S. Pincock, M.D.—1944 Seminary Rd., Silver Spring, Md.

Rose Marie Pink, M.D.—Rt. 4, 3670 Pontiac Rd., Pontiac, Mich.

Lillian Ponger, M.D.—1673 Waler Ave., Union, New Jersey.

Olga V. Pruitt, M.D.—306 W. Franklin St., Anderson, S.C.

Lucille M. Radke-Fostvedt, M.D.—701 East Francis St., Corona, Calif.
Anita E. Rapoport, M.D.—1802 E. River St., Davenport, Iowa
Lt. Col. Clara Raven, M.D.—3461 U.S. Army Hospital, Fort Rucker, Ala.
Albertine L. Rea, M.D.—Rt. 2, Box 155, Shoreland Terrace, Salem, Wis.
Elizabeth Lodge Rees, M.D.—1008 Mariposa Ave., Berkeley 7, Calif.
Georgia Reid, M.D.—35 East 35th St., New York 16, N.Y.
Glee A. Renick, M.D.—925 E. San Antonio Dr., Long Beach 7, Calif.
Rita Silverberg Reuben, M.D.—17 Dog Leg Lane, Roslyn Hts., Long Island, N.Y.
Hertha Riese, M.D.—Rt. 2, Box 397, Glen Allen, Virginia.
Cornelia F. Robertson, M.D.—Box 1269, Lakeview, Oregon.
Grace M. Robertson, M.D.—515 West 7th St., Plainfield, N.J.
Lillian Harris Robinson, M.D.—617 S. Quincy, Enid, Okla.
Harriet N. Roger, M.D.—5303 Stoneleigh, Dallas 19, Tex.
Charlotte Rosendorff, M.D.—1506 Brady, Davenport, Iowa
Jeanette Rubricius, M.D.—717 Encino Place, N.E., Albuquerque, N.M.
Mary K. Sartwell, M.D.—6811 Riggs Rd., Apt. 102, Hyattsville, Md.
Mildred Schaffhausen, M.D.—109 W. Minnehaha Parkway, Minneapolis 19, Minn.
Agnes C. Muldoon Schlichte, M.D.—19 Bernard St., Lexington, Mass.
Lily E. Lederer Schoffman, M.D.—4436-54 S.W., Seattle 8, Wash.
Marie Mueller Schuh, M.D.—8731 S.W. 43rd St., South Miami 43, Fla.
Katharine B. Scott, M.D.—138 Hancock St., Auburndale, Mass.
K. Frances Scott, M.D.—11 Jewett St., Northampton, Mass.
Isabelle D. A. Seismann, M.D.—857 Carroll St., Brooklyn 15, N.Y.
June Carol Shafer, M.D.—Arlington Towers, Jefferson Bldg., Apt. 1018, Arlington 9, Va.
Irene Shmigelski, M.D.—1416 Canfield, Park Ridge, Ill.
Hilda Bolden Shorter, M.D.—4021 19th St., N.E., Washington 18, D.C.
Vilda Shuman, M.D.—701 Laurel St., Waycross, Georgia.
Dora J. Silverman, M.D.—138 S. Sycamore St., Los Angeles, Calif.
Roslyn Skyer, M.D.—307 N. Dixie, Pan A. Bldg., West Palm Beach, Fla.
Virginia R. Sorum, M.D.—400 Deming Place, Chicago, Ill.
Martha Ellen Southard, M.D.—Dept. of Radiology, Cincinnati General Hospital, Cincinnati 29, Ohio
Rose Mary Spalo, M.D.—3201 West Harrison St., Chicago 24, Ill.
Nelda Faye Stafford, M.D.—500 Commerce Bldg., Baton Rouge, La.
Ruth Stekert, M.D.—Yardville Rd., Allentown, New Jersey.
Pearl M. Stetler, M.D.—2943 Washington, Chicago 12, Ill.
Julia Super, M.D.—6015 Tyndall Ave., Riverdale 71, N.Y.
Mabel Richards Tarbell, M.D.—695 Bryden Rd., Columbus 5, Ohio
Grace F. Thomas, M.D.—Stark County Guidance Center, 933 Market Ave. N., Canton, Ohio
Eleanor W. Townsend, M.D.—1715 Dalloz Rd., Columbia, S.C.
Patricia B. Tudbury, M.D.—1135 North Garey Ave., Pomona, Calif.
Isabel B. Turner, M.D.—302 N. Kelsay Ave., Evansville 11, Ind.
Mary W. Tyler, M.D.—1122 A North Harlem, River Forest, Ill.
Thelma Saling Varian, M.D.—1003 E. Okmulgee, Muskogee, Okla.
Emma M. Varnerin, M.D.—Gonzales Warm Springs Foundation, Gonzales, Tex.
Dorothy J. Vinton, M.D.—2455 N.W. Marshall, Suite 5, Portland 10, Ore.
Mary B. Waddell, M.D.—c/o San Miguel County Health Dept., Court House, Las Vegas, N.M.
Johanna Waldemar, M.D.—Still Hill Rd., Hamden, Mt. Carmel, Conn.
Helen M. Wallace, M.D.—New York Medical College, Fifth Ave. & 105th St., New York, N.Y.
Nell M. Ward, M.D.—1139 Mott Foundation Bldg., Flint 3, Mich.
Eleanor A. Waskow, M.D.—550 W. Thomas Rd., Phoenix, Ariz.
Ethel M. Waters, M.D.—650 Glarietta Blvd., Coronado, Calif.
Henriette Loewenberg Wayne, M.D.—425 Central Park W., New York 25, N.Y.
Clara S. Webster, M.D.—1911 Hawthorne St., Tucson, Ariz.
Laurel A. Weibel, M.D.—5211 Arbor Rd., Long Beach 11, Calif.
Fay B. Weinstein, M.D.—2940 Euclid Hts. Blvd., Cleveland 18, Ohio
Gloria Weir, M.D.—4773 Convention, Baton Rouge, La.
Helen B. Weyrauch, M.D.—350 Post St., San Francisco 8, Calif.
Frances E. White, M.D.—505 Medical Dental Bldg., 233 A St., San Diego, Calif.
Theresa T. Woo, M.D.—616 W. Arlington Place, Chicago 14, Ill.
Ethyl John Wood, M.D.—3687 Willow Crest Ave., North Hollywood, Calif.
Elizabeth Workman-Lash, M.D.—4924 Highland Dr., Willoughby, Ohio
Emily E. Wright, M.D.—421 Burns Ave., Cincinnati 15, Ohio
Margaret Rislev Wright, M.D.—4562 Linden Ave., Long Beach 7, Calif.
Alma Louise Wurdemann, M.D.—1556 Ponce de Leon, Santurce, Puerto Rico
Viola Young, M.D.—10 Peterboro, Detroit 1, Mich.
Margaret H. Zolen, M.D.—628 S. Park St., Kalamazoo, Mich.

(For **Deletions** *see facing page)*

CORRECTION

Through a mechanical error, the heading intended for page 230 in the June JOURNAL actually appeared as the heading for page 231. The heading for page 230 should have been: "NEW MEMBERS—1955."

EDITORIAL FORECAST

August 1956

Dr. Grace G. Jones is the Guest Editor for the special Branch Three, Maryland, issue of the JOURNAL, to appear in August. A variety of articles will include:

"The New and the Old in the Treatment of Epilepsies: Early History," by Ruth W. Baldwin, M.D.

"Significance of Nausea and Vomiting," by Grace G. Jones, M.D.

"The Patient with Postnasal Drip," by Betty Mae Young, M.D.

"Group Therapy with Delinquent Adolescent Girls," by Rachel K. Gundry, M.D.

"A Case of Sacrococcygeal Teratoma Obstructing Delivery," by Eleanor Scott, M.D.

"Notes on College Health Services," by Grace Hiller, M.D.

There will also be material on medical women in Baltimore and information about the Branch and its history.

DELETIONS

Olga E. Allers, M.D.
Mary Lou Byrd, M.D.
Lois H. Brock, M.D.
Anne F. Casper, M.D.
Elizabeth Councilman, M.D.
Nila K. Covalt, M.D.
Sarah E. Flanders, M.D.
Ruth Fox, M.D.
Adele Gecht, M.D.
Matie Elaine Green, M.D.
Julia Ford Hill, M.D.
Ursula M. Hober, M.D.
Lois Dean Hubbard, M.D.
Selma B. Hyman, M.D.
Mary C. Jaquette, M.D.
Jessie M. Peterson Janjigian, M.D.
Juanita P. Johns, M.D.
Louise O. Kappes, M.D.
Helen Kastner, M.D.
Amy Louise Kuhn, M.D.
Katherine Leicester, M.D.
Lucile Lord-Heinstein, M.D.
Grace Loveland, M.D.
Teresa McGovern, M.D.
Harriet McIntosh, M.D.
Felipa A. Marquina, M.D.
Evelyn Z. Merrick, M.D.
Mary L. M. Montgomery-Marsh, M.D.
Gertrude F. Mitchell, M.D.
Eugenia E. Murphy, M.D.
Dorothy Klenke Nash, M.D.
Estella G. Norman, M.D.
Helene Papanek, M.D.
Ada R. Perel, M.D.
Grace G. Purse, M.D.
Alice Hill Pye, M.D.
Amelia Link Sheppard, M.D.
Marion L. Siler, M.D.
Esther Somerfeld-Ziskind, M.D.
Berenice Stone, M.D.
Ruth Elaine Taylor, M.D.
Eleanor Triboletti, M.D.
Ynez Coit Tyler, M.D.
Emily Woelz, M.D.
Ruth Zuckerman, M.D.

A stitch in time saves ----

Something missing? Sure—that important last word!

When you prescribe prenatal capsules, the word to remember is *Lederle*. Write it, and assure your patient the genuine Lederle formula!

PRENATAL CAPSULES LEDERLE

Dosage: 1 to 3 capsules daily, throughout pregnancy and lactation.

Each capsule contains:

Vitamin A	2000 U.S.P. Units	Folic Acid	1 mg.
Vitamin D	400 U.S.P. Units	Calcium (in $CaHPO_4$)	250 mg.
Thiamine Mononitrate (B_1)	2 mg.	Phosphorus (in $CaHPO_4$)	190 mg.
Riboflavin (B_2)	2 mg.	Dicalcium Phosphate Anhydrous ($CaHPO_4$)	869 mg.
Niacinamide	7 mg.		
Vitamin B_{12}	1 mcgm.	Iron (in $FeSO_4$)	6 mg.
Vitamin K (Menadione)	0.5 mg.	Ferrous Sulfate Exsiccated	20 mg.
Ascorbic Acid (C)	35 mg.	Manganese (in $MnSO_4$)	0.12 mg.

dry-filled sealed capsules — a Lederle exclusive! More rapidly and completely absorbed. No oils, no paste . . . no aftertaste.

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* PEARL RIVER, NEW YORK

Lederle

For bigger appetites and better health—at any age

Redisol®

CRYSTALLINE VITAMIN B_{12}

MAJOR ADVANTAGES: Helps patients gain weight. Stimulates hemopoiesis. Elixir and Tablets readily blend with milk, juices and infant formulas.

Supplied as REDISOL Soluble *Tablets:* 25, 50, 100 *mcg.;* cherry-flavored *Elixir:* 5 *mcg.* per 5 cc.; *Injectable:* 30, 100, 1000 *mcg.* per cc.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF
MERCK & CO., INC.

AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

APPLICATION FOR MEMBERSHIP

Name ..... Date ....
(Please print as it should appear in the Directory.)

Address (Present) .....

Address (Permanent) .....
(Please check address to which JOURNAL and AMWA correspondence are to be mailed.)

Medical School .....Year of Graduation .....

Licensed in County .....State .....

Specialty .....Certification by American Board of.....Year....

Date and Place of Birth .....

Medical Society Affiliations .....

.....

.....

Hospital and Faculty Appointments .....

.....

Public Health, Government, or Industrial Appointments .....

.....

.....

Check membership desired:

☐ Life-Dues $200 (May be paid in two installments in two consecutive years).

☐ Active-Dues $10 per annum. (Branch dues not included in Active membership dues and are payable to Branch treasurer.)

☐ Associate-No dues.

☐ Junior-No dues.

American Medical Women's Association, Inc.

BRANCH OFFICERS 1955-1956—(Continued)

FORTY-ONE, SOUTHEAST VIRGINIA

President: Hertha Riese, M.D., Route 2, Box 397, Glen Allen.

Secretary: Maysville Owens Page, M.D., 2904 Rugby Road, Richmond.

FORTY-TWO, HOUSTON, TEXAS

President: Ruth Hartgraves, M.D., 1407 Medical Arts Building, Houston.

Secretary: Francine Jensen, M.D., 2218 West Main, Houston 6

FORTY-THREE, THE ALAMO, SAN ANTONIO, TEXAS

President: Mary Mitchell Henry, M.D., 601 Medical Arts Building, San Antonio.

Secretary: Ione Huntington, M.D., 647 New Moore Building, San Antonio.

Membership Chairman: Pearl Zink, M.D., 615 Medical Arts Building, San Antonio.

FORTY-FOUR, MARICOPA, PHOENIX, ARIZONA

President: Zdenka Hurianek, M.D., 4115 North 10th, Phoenix.

Secretary: Helen Davis, M.D., 3337 East Mitchell Dr., San Antonio.

BRANCH FORTY-FIVE, TUCSON, ARIZONA

President: Virginia C. Van Meter, M.D., Old Pueblo Club, Tuscon.

BRANCH FORTY-SEVEN, COLORADO

President: Mildred Doster, M.D., 414 Fourteenth St., Denver 2.

BRANCH FORTY-EIGHT, NORTHWEST INDIANA

President: Eleanore A. Walters, M.D., 602 Broadway, Gary.

Secretary: Ellen K. Cohen, M.D., Hebron.

CONSTITUTION OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

Article III, Section 1a. **Active Members** "shall be members of a Branch, if any local Branch exists; if not, they may be Members-at-large."

Article III, Section 6. **Associate Members** "shall be: (1) Medical women in the first year of practice; (2) women interns, residents-in-training, and fellows. Associate members shall not pay dues and shall have all privileges of memberships, except voting, holding office, and membership in the Medical Women's International Association."

Article III, Section 7. **Junior Members** "shall be members of Junior Branches in the four undergraduate years of medical school."

All members receive the official publication, the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION. Life and Active members receive membership in the Medical Women's International Association.

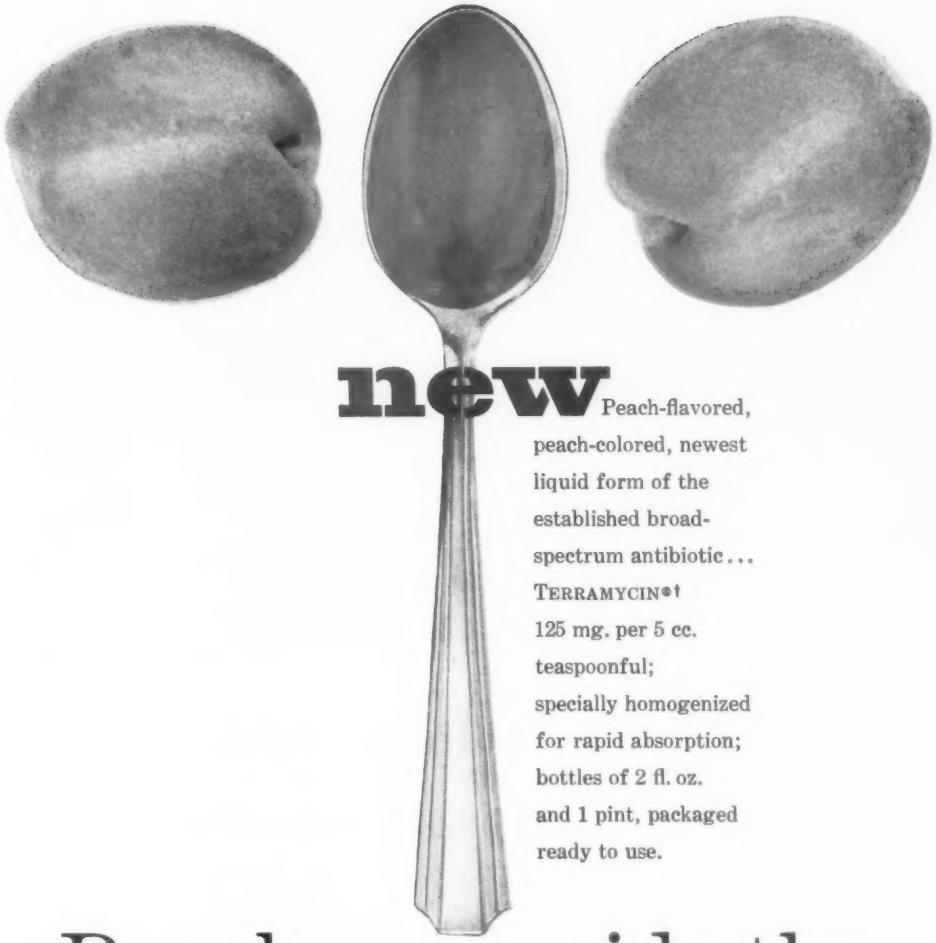
Signature.....

Endorsers are required only if applicant is NOT a member of a State or County medical society. Endorsers must be members of American Medical Women's Association.

Endorser: 1. ..... Address.....

2. ..... Address.....

Checks payable to the American Medical Women's Association, Inc. must accompany application. Mail to Treasurer, A.M.W.A., 1790 Broadway, Room 409, New York 19, New York, or to Branch Treasurer.



new Peach-flavored, peach-colored, newest liquid form of the established broad-spectrum antibiotic... TERRAMYCIN®† 125 mg. per 5 cc. teaspoonful; specially homogenized for rapid absorption; bottles of 2 fl. oz. and 1 pint, packaged ready to use.

Peaches provide the delightful new taste in

TERRABON®

BRAND OF OXYTETRACYCLINE

HOMOGENIZED MIXTURE

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y. Pfizer

†Brand of oxytetracycline

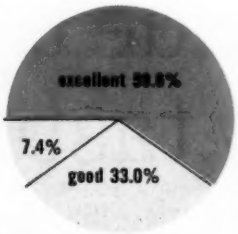
over 90% effective in infant colic

relief usually within 24-48 hours

PEDIATRIC PIPTAL®

anticolic

effective: 92.6%



well tolerated: 93.5%

dosage: For colic, administer 0.5 cc. with dropper supplied, directly into mouth of infant 15 minutes before feeding, on a demand-feeding schedule. In some severe cases, 1 cc. may be advisable. For spitting, vomiting, pylorospasm, cardiospasm and other functional gastrointestinal disorders, 0.5 to 1 cc., q.i.d., by dropper or in milk, formula or fruit juice.

supplied: 30-cc. dropper bottles, with droppers calibrated to deliver 0.5 cc. Each cc. contains 4 mg. of PIPTAL and 6 mg. of phenobarbital (warning: may be habit-forming).

PIPTAL is the only brand of N-ethyl-3-piperidyl-benzilate methobromide.

Andelman, M. B.; Nathan, L. A.; Breslow, L., and Gerber, H.: Scientific Exhibit, American Academy of Pediatrics, Chicago, Ill., Oct. 3-6, 1955.

LAKESIDE

To build giant-size appetites, prescribe...

Redisol®

CRYSTALLINE VITAMIN B_{12}

MAJOR ADVANTAGES: Helps youngsters gain weight. Stimulates hemopoiesis. Cherry-flavored *Elixir* or soluble *Tablets* readily blend with milk, juices, infant formulas.

Supplied as REDISOL *Tablets:* 25,50, 100, 250 *mcg.; Elixir: 5 mcg.* per 5 cc.; *Injectable:* 30, 100, 1000 *mcg.* per cc.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF
MERCK & CO., INC.

AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

1790 Broadway **New York 19, N.Y.**

APPLICATION FOR ASSOCIATE MEMBERSHIP

Name.....Date.....

Address.....Present

Address.....Permanent

Please print or type name and address. Check address to which JOURNAL is to be mailed.

Medical School.....Year of Graduation.....

Place of Internship.....

Date of Birth.....Place of Birth.....

Associate members do not pay dues but have all the privileges of membership except voting, holding office, and membership in the Medical Women's International Association. Associate membership is open to: medical women in the first year of practice, women interns, residents in training, and fellows. Membership includes the JOURNAL each month without charge.

.....Signature

INDEX TO ADVERTISERS

Abbott Laboratories ..... (8-9), 35
Ayerst Laboratories ..... —
Beech Nut Packing Company 19
Bristol-Myers Company 15
Ciba 1, 2
Coca-Cola ..... —
Esta Medical Laboratories ..... —
Hoffmann-La Roche, Inc. ..... (16-17), 25
Holland-Rantos, Inc. ..... —
Johnson & Johnson, Inc. 5, 36
Lakeside Laboratories 32
Lederle Laboratories 22-23, 28
Eli Lilly & Company 26
The S. E. Massengill Company 16
Mead Johnson & Company ..... Back Cover
Ortho Pharmaceutical Corp. ..... —
Parke Davis & Company, Inc. 7
Pfizer Laboratories 13, 31
Riker Laboratories ..... Inside front cover
J. B. Roerig & Company ..... —
Schering Corporation ..... —
Sharp & Dohme ..... 8, 29, 33, Inside back cover
Smith, Kline & French Laboratories 21
Tampax Incorporated 11
The Upjohn Company 4
Winthrop Laboratories, Inc. 12

INDEX TO PRODUCTS ADVERTISED

Antacids
Sal Hepatica *(Bristol-Myers)* 15

Anorexigenic Agents
Altepose *(Sharp & Dohme)* ... Ins. back cover
Dexedrine Sulfate *(Smith, Kline)* 21

Antiarthritics
Sterane *(Pfizer)* 13

Antibiotics
Achromycin *(Lederle)* 22-23
Terrabon *(Pfizer)* 31

Anticolics
Pediatric Piptal *(Lakeside)* 32

Antidepressants
Dexedrine Sulfate *(Smith, Kline)* 21

Antihistaminics
Plimasin *(Ciba)* 2
Co-Pyronil *(Lilly)* 26

Antihypertensives
Rauwiloid *(Riker)* ..... Ins. front cover

Baby Products
Baby Powder *(Johnson & Johnson)* 36
Baby Shampoo *(Johnson & Johnson)* 5
Beech Nut Foods *(Beech-Nut)* 19

Dietary Supplements
Redisol *(Sharp & Dohme)* 8, 29, 33, 35
Sur-Bex with C *(Abbott)* 35
Vi-Penta *(Hoffmann-La Roche)* ..... (16-17)

—Prenatal
Natabec Kapseals *(Parke-Davis)* 7
Natalins *(Mead Johnson)* ..... Back cover
Prenatal Capsules *(Lederle)* 28

Emotional Stabilizers
Serpatilin *(Ciba)* 1

Hypnotics
Placidyl *(Abbott)* ..... (8-9)

Laxatives
Sal Hepatica *(Bristol-Myers)* 15

Sedatives
Placidyl *(Abbott)* ..... (8-9)

Selenium Sulfide
Selsun *(Abbott)* ..... (8-9)

Sulfonamides
Azo-Gantrisin *(Hoffmann-La Roche)* 25
Gantrisin Suspension
(Hoffmann-La Roche) ..... (16-17)

Tampons
Tampax *(Tampax)* 11

Ulcer Protection
Pamine *(Upjohn)* 4

Vaginal Therapeutics
Milibis *(Winthrop)* 12
Massengill Powder *(Massengill)* 16

Each SUR-BEX with C tablet contains:

Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	1 mg.
Vitamin B_{12} *(as cobalamin concentrate)*	2 mcg.
Calcium Pantothenate	10 mg.
Ascorbic Acid	150 mg.
Liver Fraction 2, N. F.	300 mg. (5 grs.)
Brewer's Yeast, Dried	150 mg. (2½ grs.)

As a dietary supplement: 1 or 2 tablets daily.

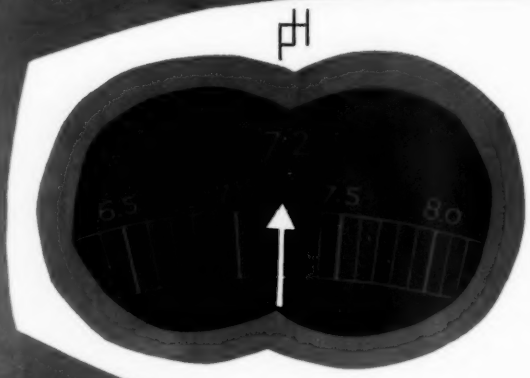
For stress, or postoperative convalescence: 2 or more tablets daily.

607206

Abbott

unique protection, lubrication, comfort

PROOF



protective buffering action

Johnson's Baby Powder has an exclusive buffering agent—with an optimal pH—to neutralize excessive acidity and alkalinity, help minimize irritation.

soothes, prevents chafing

Unique, uniform flat platelets glide smoothly over skin... give excellent lubricant action.

combats miliaria, other irritations

Contains no oils, does not occlude skin. Blots up moisture, permits rapid evaporation... avoids clogging pores or macerating of skin.

bettering baby care through specialized research

BABY PRODUCTS DIVISION

Johnson & Johnson

Altepose®

keeps her appetite—and weight—under control

MAJOR ADVANTAGES: 1. Overcomes excessive craving for food. 2. Reduces tissue water retention. 3. Alleviates nervousness and irritability.

It's much easier for your overweight patient to pass up rich food—when she's taking ALTEPOSE. For ALTEPOSE contains 3 important ingredients which help overweights stay on their reducing diets.

1. *Propadrine*® controls the patient's craving for food—yet causes less central stimulation than does either ephedrine or amphetamine.

2. *Thyroid* helps release tissue-bound water—thus brings about weight-loss *early* in the dieting period.

3. *Delvinal*® relieves the irritability so often associated with rigid diets. Patients feel happier.

Each ALTEPOSE Tablet contains 50 *mg.* 'Propadrine' HCl, 40 *mg.* thyroid and 25 *mg.* 'Delvinal.'

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

MEAD

Gravida II
Para I

...and on the go

Modern, active, on the go...and pregnant. That's why she needs a vitamin-mineral supplement generously formulated especially for the stress of pregnancy.

Natalins-PF and Natalins are designed for the busy, modern woman. Small in size, they're easy to take. Just 1 capsule t.i.d. provides more than ample nutritional support.

specify

Natalins-PF

Mead phosphorus-free prenatal vitamin-mineral capsules

Contain calcium... no phosphorus

or

Natalins®

Mead prenatal vitamin-mineral capsules

Contain both calcium and phosphorus

MEAD SYMBOL OF SERVICE IN MEDICINE

MEAD JOHNSON & COMPANY, EVANSVILLE 21, INDIANA, U.S.A.